

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34234**
Registrar's No. **8772**

Registration District No. **1003** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **1003**
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution:
5133 Vernon Ave.,
(d) Length of stay: In hospital or institution **42 Yers**
In this community **42 Yers**

3. (a) PRINT FULL NAME **Raymond F. Miller**
(b) If veteran, name war **No**
(c) Social Security No. **492-09-4700**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Amanda L. Miller**
6. (c) Age of husband or wife if alive **42** years
7. Birth date of deceased **Sept. 25, 1897**

8. AGE: Years **42** Months **--** Days **18**
If less than one day hr. min.

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Clerk**

11. Industry or business **Sears Roebuck Co.**

MOTHER FATHER
12. Name **Jos. P. Miller**
13. Birthplace **St. Louis, Mo.**
14. Maiden name **Anna Meyer**
15. Birthplace **St. Louis, Mo.**

16. (a) Informant's own signature **Amanda L. Miller**
(b) Address **5133 Vernon Ave.,**

17. (a) **Burial** (b) Date thereof **Oct. 16, 1939**
(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Wm. F. Paschedag**
(b) Address **2825 N. Grand Blvd.**

19. (a) **OCT 15 1939** (b) **J.P. Baskette**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **1**
(c) City or town **St. Louis**
(d) Street No. **5133 Vernon Ave.,**
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **13th**
year **1939** hour **8** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **January 16th, 1939, to October 13th, 1939;**
that I last saw him alive on **October 12th, 1939;**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of glands of neck.**
Due to: **Carcinoma metastatic to chest (Lungs) primary site pt. submaxillary glands.**
Other conditions: _____
(Include pregnancy within 3 months of death)

Duration **10 months**

Major findings: **glands of neck removed carcinoma**
Of operations **none**
Of autopsy **none**

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **none**
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Scott Hemen MD**
Address **634 N Grand St. Louis** Date signed **10/14/39**

WHILE FILLING IN USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X1931

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed Guiz W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.