

WRITE PLAINLY—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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

34565

Registration District No.

791
1008

Primary Registration District No.

Registrar's No.

9103

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution Since 7/3/39
(Specify whether
In this community
years, months or days)

8. (a) PRINT FULL NAME Eliza Miller 4600
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 2, 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>8</u>	<u>17</u>	hr. min.

9. Birthplace Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Peter Paok

13. Birthplace Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Emma

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arthur Map Shea

(b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 10-26-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Apra Hamilton

(b) Address City Health Dept

19. (a) OCT 25 1939 (b) _____
(Date of recording) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 5 Hamilton Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19
year 1939 hour 10 minute 30 a. M.

21. I hereby certify that I attended the deceased from July 3, 1939
_____, 19____, to Sept. 19, 1939, 19____;
that I last saw her alive on Sept. 19, 1939, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis Duration abt 3 yrs

Due to ---
Due to ---

Other conditions Pulmonary congestion (Edema)
(Include pregnancy within 3 months of death)

no Pneumonia nor tuberculosis PHYSICIAN

Major findings: _____

Of operations ---

Of autopsy ---

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) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. J. Lyman (M. D. or other) _____

Address 2601 N Whittier Date signed 9/28/39

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.....

Licensed Embalmer No.....

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.