

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FORM 5-17-39 I X1951

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

34768

State File No.

9306

Registrar's No.

NOV 13 1939

Registration District No.

791

Primary Registration District No.

1. PLACE OF DEATH:

1002

- (a) County St. Louis
- (b) City or town St. Louis ³
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: Enterprise Home Hospital
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME John MILLER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9/30/39
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation nil

11. Industry or business _____

12. Name Andrew Miller

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

14. Maiden name Edith Evans
15. Birthplace Miss
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Andrew Miller

(b) Address 1126 No 14 St

17. (a) _____ (b) Date thereof 10-16-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 3500 Ridge

OCT 31 1939

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County _____
- (c) City or town St. Louis ²⁵
(If outside city or town limits, write "RURAL")
- (d) Street No. 1126 No 14 St
(If rural, give location)
- (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 1 year 1939 hour 11 minute P. M.

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

Immediate cause of death Atlectasis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 Joseph M. Johnson (M. D. or other) _____

Address Deputy Coroner

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.