

Registration District No. 445

Primary Registration District No. 5580

Registrar's No. 12-46

NOV 9 1939

1. PLACE OF DEATH:

(a) County JEFFERSON  
 (b) City or town RURAL - MERAMEC  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST. JOSEPH'S HILL INFIRMARY  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 DAYS  
(Specify whether  
 In this community  
years, months or days)

3. (a) PRINT FULL NAME CHARLES W. MILLER 410  
 3. (b) If veteran, name war DO NOT KNOW  
 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced DIVORCED  
 6. (b) Name of husband or wife AMANDA HARTMAN  
 6. (c) Age of husband or wife if alive DO NOT KNOW years  
 7. Birth date of deceased 7 21 1875  
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 22  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation GOLD + SILVER REFINER, RETIRED

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name FREDERICK MILLER  
 13. Birthplace GERMANY  
(City, town, or county) (State or foreign country)  
 14. Maiden name MARY SCHLEAFER  
 15. Birthplace GERMANY  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Brother Bonaventura, O.F.S.  
 (b) Address St. Joseph's Hill Infirmary  
 17. (a) Cremation (b) Date thereof Oct 11, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Wich Bros and  
 (b) Address 2201 S Grand St Louis  
 19. (a) 9 Oct 39 (b) James A. Dronowski  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS  
 (c) City or town CRESCENT  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9  
 year 1939 hour Five minute 50 A.M.

21. I hereby certify that I attended the deceased from Oct  
Fourth, 1939, to Oct. 6, 1939;  
 that I last saw him alive on Oct. 6, 1939;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Carcinoma of Mouth + Tongue  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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?  
(Specify type of place)

While at work \_\_\_\_\_ Means of injury \_\_\_\_\_  
 23. Signature Leise S. Sargent (M. D. or other) \_\_\_\_\_  
 Address Courcha Mo. Date signed 10-9-39

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.

1 X1081

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**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 Nancy Stewart

Licensed Embalmer No. 3722

P. O. Address St Louis Mo.

**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.**

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

36448 Do not use this space.

1. PLACE OF DEATH

(a) County Jefferson Registration District No. 425- (b) Township Mexsmae Primary Registration District No. 2580 (c) City (d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Chas W. Miller St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Div

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 64 2 22

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9 1939

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19.

I last saw h. alive on , 19. Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of mouth & tongue Started in tongue, spread to mouth and chin eating away lower jaw. Date of onset

Name of operation 45 Date of What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19 Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify J.S. Sargent, M. D. (Signed) Euseba (Address)

SUPPLEMENTARY

