

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **37893**Registrar's No. **9732**

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 1
 (b) City or town St. Louis, Mo.
 (c) Name of hospital or institution: CITY HOSPITAL #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Leeta Miles 420

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased April 30 1902
(Month) (Day) (Year)8. AGE: Years 37 Months 6 Days 11 If less than one day _____ hr. _____ min.9. Birthplace Fisk, Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Laborer 011. Industry or business WARNER Bro. Drug. 112. Name C.R. Miles 113. Birthplace Tennessee
(City, town, or county) (State or foreign country)14. Maiden name Elizabeth Greer15. Birthplace Fairfield, Illinois
(City, town, or county) (State or foreign country)16. (a) Informant's own signature A. Charles Miles(b) Address 911 Summitt E. St. Louis17. (a) Removal (b) Date thereof 11/15/39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Ashley, Ill.18. (a) Signature of funeral director Albert H. Hoppe.(b) Address 4700 Washington Ave.19. (a) NOV 15 1939 (b) [Signature]
(Date received and registered) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County NR
 (c) City or town East St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1240 Gatey
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11th
year 1939 hour 11:35 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 _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

Duration

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) _____
 (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)
Means of injury _____23. Signature [Signature] (M. D. or other) _____
Address [Signature] _____

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.

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 *J. G. Sullivan*

Licensed Embalmer No. *1122*

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.