DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 13 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38320

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 10159

1. PLACE OF DEATH:

(a) County _____

(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 G. Phillips Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community Unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1826 Goode Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Floyd Miller

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

4. Sex M 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jennie Miller 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased May (Month) 29 (Day) 1878 (Year)

8. AGE: Years 61 Months 5 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

FATHER
12. Name Gum Miller
13. Birthplace _____ (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Susie Dodson
15. Birthplace _____ (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant's own signature Esther M. Sherard
(b) Address 2601 N. Whittier St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-39 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Ira Hamilton
(b) Address City Health Dept

19. (a) NOV 29 1939 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 29 year 1939 hour 6:47 minute P. M.

21. I hereby certify that I attended the deceased from 10-24- 1939 to 10-29- 1939 that I last saw him alive on 10-29- 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Arteriosclerosis (Gen.)	About 8 mos
Due to Cardiac Hypertrophy	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy As above	

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

23. Signature Henry E. Stampton (M. D. or other)
Address 2601 N. Whittier St. Date signed 10-31-39

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 I X19511

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.