DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 533

Registration District No. 791 Primary Registration District No. Registrar's No. 533

1. PLACE OF DEATH: 1003 FILED FEB 17 1940

(a) County

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2635 Park Ave. 2 (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)

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. 2635 Park Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? No Physician in Attendance years.

3. (a) PRINT FULL NAME WILBERN MILES 4 2 1

3. (b) If veteran, name war nil

3. (c) Social Security No. 497-05-0305

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Melvina Miles

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Jan. (Month) 29 (Day) 1880 (Year)

8. AGE: Years 59 Months 11 Days 19 If less than one day hr. min.

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

10. Usual occupation Packer P. M. STEEL

11. Industry or business ~~John Miles~~ PRODUCTS

FATHER
12. Name John Miles
13. Birthplace Essex (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Miles

(b) Address 2635 Park Ave.

17. (a) Burial- (Burial, cremation, or removal) (b) Date thereof Jan. 20-40 (Month) (Day) (Year)

(c) Place: burial or cremation St. Marcus Cemetery

18. (a) Signature of funeral director Wm C Maydell

(b) Address 1926 Allen Ave.

19. (a) JAN 19 1940 (Date received local registrar) (b) J. F. Bachuck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17 year 1940 hour 10:40 minute P. M.

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

Immediate cause of death Lobar Pneumonia

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph M. Dickson (M. D. or other)

Address Deputy Coro Date signed

(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. 8-17-39 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 Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen

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.