

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

State File No. 9187

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2670

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:
5412 Cabanne 7
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 2 years
 years, months or days)

3. (a) PRINT FULL NAME ADDIE HELEN MYLER

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

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Jan. 1867
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 2 ? _____ hr. _____ min.

9. Birthplace Southern Ind.
 (City, town, or county) (State or foreign country)

10. Usual occupation Multigrapher

11. Industry or business Multigraphing

12. Name Dr. J. M. Myler

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

14. Maiden name Elizabeth Richardson

15. Birthplace Southern Ind.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm. B. A. Madsen

(b) Address 5412 Cabanne Ave.

17. (a) Cremation (b) Date thereof 3/22/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Alexander & Sons

(b) Address 6175 Delmar

19. (a) MAR 22 1940 (b) J. J. [Signature]
 (Date received for registration) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 5
 (If outside city or town limits, write "RURAL")

(d) Street No. 5412 Cabanne
 (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 21
 year 1940 hour 9 minute 15 P. M.

21. I hereby certify that I attended the deceased from
Jan. 7, 1940, to Mar. 21, 1940
 that I last saw he alive on Mar. 20, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Chc. myocarditis Duration ?

Due to Hypertension !

Due to 930

Other conditions 930
 (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 Edwin P. Meiner (M. D. or other) _____

Address 6651 Euwright Date signed 3-22-40

PHYSICIAN

Underline the cause to which death should be charged statistically

Not embalmed *CP*

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.