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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED AUG 5 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26330

Registration District No. 784 Primary Registration District No. 111 Registrar's No. 1449

1. PLACE OF DEATH:

(a) County St. Louis 1

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

(c) Name of hospital or institution: St. Mary's Hospital
(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 Mo. (b) County St. Louis

(c) City or town Wellston
(If outside city or town limits, write "RURAL")

(d) Street No. 6755 Roberts Ave.,
(If rural, give location)

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

3. (a) PRINT FULL NAME Herman F. Mikels 242

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Elizabeth Mikels

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Aug. 3, 1861.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	11	28	hr. min.

9. Birthplace _____ (City, town, or county) Germany (State or foreign country) 6

10. Usual occupation Retired Insurance Man 6

11. Industry or business _____

FATHER
12. Name Fredrick Mikels 6
13. Birthplace _____ (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Elizabeth ?
15. Birthplace _____ (City, town, or county) Germany (State or foreign country)

16. (a) Informant Mrs. Elizabeth Mikels
(b) Address 6755 Roberts Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3/40. (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) AUG - 2 1940 (Date received local registrar) (b) R. Meyer M.D. Sec'y (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1940 hour 9.20 minute P.M. M.

21. I hereby certify that I attended the deceased from July 28, 1940, to July 31, 1940;
that I last saw him alive on _____, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Heat Exhaustion & Senility	
Due to Myocarditis & Cardio Renal Disease	
Due to	
Other conditions Post Operation Ventral Hernia (Include pregnancy within 3 months of death)	

Major findings:
Of operations _____
Of autopsy None ; 935

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 None
(c) Where did injury occur? None (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? No (e) Means of injury _____

23. Signature Pierce Reilly (M. D. or other) 1
Address 6125 Bartmer Date signed 8/1/40

(Licensed Embalmer's Statement on Reverse Side)

Dr. P.J.Reilly

JAN 4 1944

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 Jas. W. Clark

Licensed Embalmer No. 1661.

P. O. Address 1125 Hodiamont Ave.,

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.