

Registration District No. **7911**

Primary Registration District No. **1003**

Registrar's No. **9085**

**FILED DEC 11 1940**

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:  
Lutheran Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days)

In this community 48 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis **24**  
(If outside city or town limits, write "RURAL")

(d) Street No. 3810 Koscuisko  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mathilda B. Miller

3. (b) If veteran, name war ---

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Charles F. Miller

6. (c) Age of husband or wife if alive 9-- years

7. Birth date of deceased November 25, 1854  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>11</u>	<u>6</u>	<u>1</u> hr. _____ min.

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

10. Usual occupation Home

11. Industry or business \_\_\_\_\_

12. Name Unknown Grohmann

13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Chas. T. Miller

(b) Address 3810 Koscuisko

17. (a) Burial (b) Date thereof 11/5/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Wacker-Welderte  
2331 S. Broadway

(b) Address \_\_\_\_\_

19. (a) NOV 4 1940 (Date received local registrar)  
J.F. Brudich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1  
year 1940 hour 8 minute 13p. M.

21. I hereby certify that I attended the deceased from Oct 21, 1940, to Nov. 1, 1940  
that I last saw her alive on Nov. 1, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Myocardial Infarction with decompensation

Due to Arteriosclerosis

Due to Senile Debility

Other conditions (Include pregnancy within 3 months of death) 050

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?  
X \_\_\_\_\_  
(Specify type of place)

While at work? X (e) Means of injury X

23. Signature Walter F. Koesper (M.D. or other) W.F.

Address 3805 So Broadway Date signed 11/2/40

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

MOTHER FATHER

**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.....

*Frank J. Wyland*

Licensed Embalmer No.....

*2675*

P. O. Address.....

*St. Louis Mo*

**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, fact should be so stated above.**