

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1037

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Royal: St. Louis

(c) Name of hospital or institution: Joseph Sanatorium

(d) Length of stay: In hospital or institution 45 days

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town: St. Louis

(d) Street No.: 1413 a Belt Avenue

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

3. (a) PRINT FULL NAME: NATHAN MILLER

3. (b) If veteran, name war: No

3. (c) Social Security No.: 499-01-3941

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1941 hour 7:5 minute \_\_\_\_\_ M.

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Rose Miller

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

7. Birth date of deceased: May 1, 1876

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 5/15/41, 19\_\_\_\_; that I last saw him alive on May 15, 19\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>0</u>	<u>14</u>	hr. _____ min. _____

Immediate cause of death: Carcinoma of stomach & metastases to peritoneum

Due to: Arteriosclerotic heart disease

9. Birthplace: Galicia Austria, Germany 4

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_

10. Usual occupation: Laborer

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

11. Industry or business: Scrap Metal

Of autopsy: \_\_\_\_\_

12. Name: Jacob L. Miller

13. Birthplace: Germany 4

14. Maiden name: Matilda Rose Glockenberg

15. Birthplace: Germany 4

16. (a) Informant: Mrs. Rose Miller

(b) Address: 1413 a Belt

17. (a) Burial (b) Date thereof: 5/16/1941

(c) Place: burial or cremation: Hevre Kedisha Berger Memorial

18. (a) Signature of funeral director: \_\_\_\_\_

(b) Address: 4715 McPherson Ave

19. (a) MAY 16 1941 (b) DR. Meyer M.D. Dep't

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? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury: \_\_\_\_\_

23. Signature: Joseph Sanatorium (M. D. or other) \_\_\_\_\_

Address: Joseph Sanatorium Date signed: 5/16/41

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

96 00

MOTHER FATHER

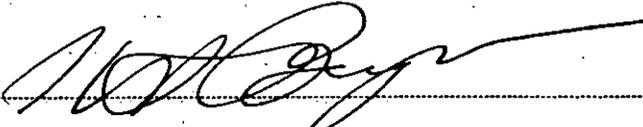
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**STATEMENT BY LICENSED EMBALMER**

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.