

477
No. 2
1-4-41
5-17-39
X25

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23424**
Registrar's No. **5776**

FILED AUG 28 1941 701

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County.....
(b) City or town. **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis, City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **7 Days**
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State. **Mo.** (b) County.....
(c) City or town. **St. Louis.**
(If outside city or town limits, write "RURAL")
(d) Street No. **2407 North 9th Street.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Margaret Miller**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **12**,
year **1941** hour **12:15** minute **P.** M.
21. I hereby certify that I attended the deceased from **July**
6, 19**41**, to **July 12**, 19**41**
that I last saw him **ET** alive on **July 12**, 19**41**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife. **Frank Miller.** 6. (c) Age of husband or wife if alive. **72** years
7. Birth date of deceased. **September 25, 1875**
(Month) (Day) (Year)

Immediate cause of death.
**Cystitis, chronic catarrhal
Papillitis, chronic non-calculous**
Duration

8. AGE: Years **65** Months **9** Days **16** If less than one day
hr. min.

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death) **1330**

9. Birthplace **St. Louis, Mo** (City, town, or county) (State or foreign country) **U**
10. Usual occupation **At Home.**

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
Underline the cause to which death should be charged statistically.

11. Industry or business.....
12. Name **John Donnelly.**
13. Birthplace **Ireland.** (City, town, or county) (State or foreign country) **U**
14. Maiden name **Eileen Barry.** (City, town, or county) (State or foreign country) **U**
15. Birthplace **Ireland.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Frank Miller.**
(b) Address **1016 North Broadway.**
17. (a) **Burial.** (b) Date thereof **7-15-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery.**

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)

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd**
19. (a) **JUL 14 1941** (Date received local registrar) (b) **J. J. [Signature]** (Registrar's signature)

While at work?..... (c) Means of injury.....
23. Signature **M. M. Karl** (M. D. or other) **11/14/41**
Address **1515 Lafayette Ave.,** Date signed

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

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, *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address. *3840 Lincoln*

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.