

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

32572  
State File No. \_\_\_\_\_  
Registrar's No. 2002

Registration District No. FILED OCT 7 1941

Primary Registration District No. 113

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Florissant  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Pierre St.  
(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)

3. (a) PRINT FULL NAME Edward H. Miles  
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Laura Clayburg Miles 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased September 26 1866  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Florissant Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Gardener

11. Industry or business \_\_\_\_\_  
12. Name John Miles  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Theresa Majors  
15. Birthplace St. Charles Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laura Miles  
(b) Address Florissant, Mo.  
17. (a) Burial (b) Date thereof 10/2/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Ferdinand Cem.

18. (a) Signature of funeral director Stroot-Carroll  
(b) Address 4600 Natural Bridge Ave.  
OCT 1 - 1941  
19. (a) \_\_\_\_\_ (b) C. H. McCarroll  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
Florissant  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. St. Pierre St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29  
year 1941 hour 1 minute 05 A.M.  
21. I hereby certify that I attended the deceased from Sept 11  
\_\_\_\_\_ 1941, to Sept 28 \_\_\_\_\_ 1941;  
that I last saw him alive on Sept 28 \_\_\_\_\_ 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic Duration 10 yrs  
Due to \_\_\_\_\_  
Due to 93d  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. C. Ahrens (M. D. or other) MD  
Address St. Louis Mo Date signed Sept 29 - 41

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

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..... *Frank H. Strong* .....

Licensed Embalmer No. 2265.....

P. O. Address 46 W. 9th Bridge .....

**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.**