

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:
City Hospital #1 X
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 minutes
(Specify whether _____)

In this community 30 years
(years, months or days)

3. (a) PRINT FULL NAME MATTIE MILLERING

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race white

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased November 30, 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>3</u>	<u>0</u>	hr. _____ min.

9. Birthplace St.-Charles County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business at home

12. Name John Keithley

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

14. Maiden name Fannie Jacobs

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

16. (a) Informant Mary Smith

(b) Address 118 E. Grand Avenue

17. (a) Burial (b) Date thereof Mar. 4, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette Avenue

19. (a) MAR 4 - 1942 (b) J. F. Bredet
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 2312
(If outside city or town limits, write "RURAL")

(d) Street No. 1520 So. 7th Street
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
No Attending Physician

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1942 hour 11:45 minute A M.

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

Immediate cause of death:
Chronic Myocarditis
Chronic Interstitial Nephritis
Tuberculosis

Due to _____

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

Major findings:
Of operations 1316

Of autopsy _____

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) _____ (or) Means of injury 3

While at work _____

23. Signature Walter Perry (M. D. or other) _____
Address _____ Date signed 3/4/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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 *L.R. Asapu*
Licensed Embalmer No. *3633*
P. O. Address *2317 Lafayette*

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.