

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19865

State File No. _____

REGISTRATION DISTRICT NO. 518

Primary Registration District No. 1003

Registrar's No. 5985

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:
BARNES HOSPITAL
(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) 1 1/2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St Clair

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

(d) Street No. Compus apt - apt-1-A
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 2

3. (a) PRINT FULL NAME ZIAPHIANA VENONA MINNER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 30
year 1943 hour 4 minute 15 A.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Cash Miller 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Dec 26 1904
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from JUNE 28
1943, to JUNE 30 1943;
that I last saw her alive on JUNE 30 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Cerebral EMBOLISM 48 hrs.

8. AGE: Years 33 Months 6 Days 29 If less than one day _____ hr. _____ min.

Due to SUBACUTE BACTERIAL ENDOCARDITIS 7 mos.

9. Birthplace Summer (City, town, or county) Ill. (State or foreign country)

Due to RHEUMATIC HEART DISEASE 21 yrs.

10. Usual occupation Housewife

Other conditions (include pregnancy within 3 months of death) _____

11. Industry or business at home

Major findings: 95 PHYSICIAN _____

12. Name Samuel Gamen

Of operations _____

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

Of autopsy _____

14. Maiden name Marjeth Kimmel

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

16. (a) Informant Chas Kurke
(b) Address 8 St Louis Ave

17. (a) ~~Place of burial or cremation~~ Bellemeade
(b) Date thereof 7 2-43
(Month) (Day) (Year)

18. (a) Signature of funeral director Chas Kurke
(b) Address 8 St Louis Ave

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. F. Bredeck (M. D. crosses) _____
Address BARNES HOSPITAL Date signed 6/30/43

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 Chas m. Burke

Licensed Embalmer No. 2421

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.