

FILED DEC 27 1943

Registration District No. _____

Primary Registration District No. **3067**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Ladue Village**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
#14 Fair Oaks /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30** (Specify whether years, months or days)
In this community **30** years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Ladue Village**
(If outside city or town limits, write "RURAL")
(d) Street No. **# 14 Fair Oaks**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MATTIE VEATCH MILLER**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **James P. Miller**
6. (c) Age of husband or wife if alive **Dec.** years
7. Birth date of deceased **12 24 1858**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 11 21 hr. _____ min.

9. Birthplace **Rockport Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Mathias Mackey**
13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Amanda Howard**
15. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edwin C. Steffen**
(b) Address **# 14 Fair Oaks**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **12-16-1943**
(Month) (Day) (Year)
(c) Place: burial or cremation **Rockport, Indiana**

18. (a) Signature of funeral director **Alexander Sons**
(b) Address **6175 Delmar Blvd.**

19. (a) **DEC 18 1943** (Date received local registrar)
(b) **E. G. McCarren, Jr.** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec**, day **16**, year **1943**, hour **6:10** minute **P** M.

21. I hereby certify that I attended the deceased from **Dec 5**, 1943, to **Dec 16**, 1943 that I last saw her alive on **Dec 16**, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Arteriosclerosis** Duration **3d**
Due to **Chronic Myocarditis** **2y**
Due to **Arteriosclerosis** **?**
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy **none made**

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Joseph Davis** (M. D. or other) **mo**
Address **313 N. 9th** Date signed **12-16-43**

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

F. H. Cystoy Jun. Home

96
12
1

707

Dr. Davie
Century Bldg.
9th + Olive

2:30 to 6:30 P.M.

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 Jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Delmar

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.