

Registration District No. **318**

Primary Registration District No. **1003**

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: **DePaul Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 hours**  
In this community **50 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1917 Hamilton**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Minnie L. Miller**  
3. (b) If veteran, name war **none**  
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan.** day **21**  
year **1944** hour **8** minute **30 P.** M.

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **not known**  
6. (c) Age of husband or wife if alive **1874** years  
7. Birth date of deceased: **Dec. 30** (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1-15-44**, 1944 to **1-21-44**, 1944  
that I last saw him alive on **1-21-44**, 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years **69** Months **0** Days **22**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death  
**Influenza**  
Duration **10 days**

9. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Dress Maker**

Due to **Bronchial pneumonia** 6 days  
Due to \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name **Not known**  
13. Birthplace **not known** (City, town, or county) (State or foreign country)  
14. Maiden name **not known**  
15. Birthplace **not known** (City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: Of operations **none**  
Of autopsy **none**

16. (a) Informant **Vernise Weis**  
(b) Address **5899 Cote Brillante**

PHYSICIAN  
Underline the cause to which death should be charged statistically.

17. (a) **burial** (b) Date thereof **1-24-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Memorial Park**

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? \_\_\_\_\_

18. (a) Signature of funeral director **F. Schumacher**  
(b) Address **3013 Meramec**  
19. (a) **JAN 24 1944** (Date received local registrar)  
**J. F. Budesh** (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature **Ray Johnson** (M. D. or other)  
Address **Ray Johnson M.D.** Date signed **1/24/44**

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 *Francis A. Williamson*

Licensed Embalmer No. *3565*

P. O. Address *St Louis*

**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.**