

FILED MAR 20 1944  
Registration District No. 8

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5344 Walsh 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis 174  
(If outside city or town limits, write "RURAL") 94

(d) Street No. 5344 Walsh St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME BELLA MILLER

3. (b) If veteran, name was None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8<sup>th</sup>  
year 1944 hour 2:45 minute 17 M.

21. I hereby certify that I attended the deceased from 3-2-44  
19\_\_\_\_, to 3-8-44 19\_\_\_\_;  
that I last saw her alive on 3-8-44 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Frank Miller

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased Aug. 4<sup>th</sup> 1874  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_

Due to Cerebral hemorrhage - (left brain stroke) 6 days

Due to Hypertension - Ch. myelitis 2 yrs.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years 69 Months 7 Days 4  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

11. Industry or business \_\_\_\_\_

12. Name unknown

13. Birthplace England 4  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace England 7  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Miller

(b) Address 5344 Walsh St.

17. (a) Burial (b) Date thereof 3-10-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Wiegand Hartmann

(b) Address 4228 So. High Highway

19. (a) MAR 9 1944 (b) J. J. Break  
(Date received local registrar) (Registrar's signature)

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)

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 D. C. Pfeiffer MD (M. D. or other) \_\_\_\_\_  
Address 45235 Kingshighway Date 8/8/44

Mr. O. E. Goffen  
Harrisburg, Pennsylvania

**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 Edwin J. McDermott

Licensed Embalmer No. 3024

P. O. Address.....

**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.**