

FILED FEB 13 1945

Registration District No. 33945

Primary Registration District No. 3069

Registrar's No. 2786

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1505 Bellevue Avenue
(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

3. (a) PRINT FULL NAME John Sidney Miller

3. (b) If veteran, name was Spanish America 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alice Vanderbrook Miller 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased April 9, 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days - If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired contractor

11. Industry or business Carpenter and building

MOTHER FATHER

12. Name John O. Miller
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Augusta nee Miller
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Alice V. Miller
(b) Address 1505 Bellevue Ave.
17. (a) Burial (b) Date thereof 1/13/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton Rd. at Concordia Lane

19. (a) JAN 12 1945 (b) E. H. McShann (Registrar's signature) Address 7050 Dale Avenue Date signed 1/11/45

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 1505 Bellevue Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9
year 1945 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from January 9, 1945 to January 9, 1945
that I last saw him alive on January 9, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: No operation
Of autopsy No autopsy
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 _____
Signature Clifford J. Bendier (M. D. or D.V.M.)
Address 7050 Dale Avenue Date signed 1/11/45

MAR - 6 1945

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 *Robert J. Lambert*
Licensed Embalmer No. 1994
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.