

FILED MAY 12 1945

318

Primary Registration District No.

1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County  
(b) City or town St. Louis, Mo.  
(c) Name of hospital or institution: Homer G. Phillips Hospital  
(d) Length of stay: In hospital or institution 26 hours  
In this community 45 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis,  
(d) Street No. 4046 Fairfax  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Margarite Miller

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Fe. 3 5. Color or race Negro 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Thomas Miller 6. (c) Age of husband or wife if alive 46 years  
7. Birth date of deceased aug 22 1898

8. AGE: Years 46 Months 8 Days 7 If less than one day hr. min.

9. Birthplace Brunswick, Miss

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name Armeda Haynes  
13. Birthplace Miss  
14. Maiden name Eatherine  
15. Birthplace Miss

16. (a) Informant Gayle Davis

(b) Address 4046 Fairfax

17. (a) Burial (b) Date thereof 4/3/45

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Boyd Bros

(b) Address 3704 Family Ave

19. (a) MAY 3 1945 (b) Registrar's signature J. F. Braddock

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29, year 1945 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 29, 1945 to April 29, 1945  
that I last saw her alive on April 29, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration Unk.

Due to 82

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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. Murphy (M. D. or other) Dr. Whitehead

Date signed 4/30/45

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  
*James A. Johnson*, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

*James A. Johnson*

Licensed Embalmer No. *3522*

P. O. Address *3704 Finney Ave*

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.