V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15392

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4485

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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
3635 Flad Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000-
(c) City or town St Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 3635 Flad (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Fielding L Miller
3. (b) If veteran, name war nil
3. (c) Social Security No. 467-01-4759
4. Sex Male
5. Color or race W.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lea Miller
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Nov. (Month) 22 (Day) 1883 (Year)

8. AGE: Years	Months	Days	If less than one day
61	5	28	hr. min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation Waiter
11. Industry or business
FATHER 12. Name Geo Miller
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name Margaret McLaren
15. Birthplace Unknown (City, town, or county) Ca (State or foreign country)
16. (a) Informant Mrs Lea Miller
(b) Address 3635 Flad
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director Guy Miller
(b) Address 5041 Delmar
19. (a) MAY 21 1945 (Date received by local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1945 hour 5 30 minute P. M.
21. I hereby certify that I attended the deceased from 4/27/45, 19..., to 5/19/45, 19...; that I last saw him alive on 5/19, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	Suddenly
Due to Coronary Artery Disease	1
Due to	
Other conditions (Include pregnancy within 3 months of death) none	
Major findings: Of operations none	
Of autopsy no	

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) no
(b) Date of occurrence no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)
While at work? (e) Means of injury
23. Signature Preston C. Kall (M.D. or other) MD
Address 3902a Lafayette Date signed 5/21/45

(Licensed Embalmer's Statement on Reverse Side)

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 Samuel H. Rowland

Licensed Embalmer No. 3114

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.