

S. No. 2.  
M-5-43  
5-17-39  
I X36671

FILED SEP 21 1945  
318

Primary Registration District No. 1003

Registrar's No.

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:  
City Isolation Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution From 8-25-1945  
In this community to Sept. 11, 1945. (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. 117 No. 6th Street, 25  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME John Miller  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex Male 0  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased March 7, 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 6 4 hr. min.

9. Birthplace Peddler  
(City, town, or county) (State or foreign country)

10. Usual occupation Peddler

11. Industry or business.....

12. Name John J. Miller

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

14. Maiden name Ellen Grads

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

16. (a) Informant Edith V. Minor

(b) Address 5600 Arsenal Street

17. (a) PURIA (b) Date thereof Sept 15 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Stephen Kelly

(b) Address 4386 Lindell

19. SEP 16 1945 (b) J. M. Bredek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 11,  
year 1945 hour 12 minute 55 P.M.

21. I hereby certify that I attended the deceased from August 25, 1945, 19..... to September 11, 1945; that I last saw him alive on September 11, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Carcinoma

Due to Carcinoma of Prostrate

Due to.....

Other conditions (Include pregnancy within 3 months of death) 51

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 Palmer (M. D. or other).....

Address 5600 Arsenal Street Date signed 9-11-45

Duration  
1945

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

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

*James A. Lammers*

Licensed Embalmer No. ....

*34142*

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.**

Registration District No. 316

Primary Registration District No. 1003

Registrar's No. 8069

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:  
(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 Miller

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased mar 7. (b) (Day) (Year)

8. AGE: Years 75 Months 6 Days 10 If less than one day hr. min.

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

10. Usual occupation peddler

11. Industry or business

12. Name.....  
 13. Birthplace..... (City, town, or county) (State or foreign country)  
 14. Maiden name.....  
 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....  
 (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
 (b) Address.....

19. (a) Oct 15 1945 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits, write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....  
 that I last saw him..... alive on....., 19.....  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations.....  
 Of 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.....

23. Signature..... (M. D. or other).....  
 Address..... Date signed.....

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

**SUPPLEMENTARY**

1945  
S-29250