U. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34665

FILED NOV 3 1945

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2474

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

1. PLACE OF DEATH:
(a) County St. Louis,
(b) City or town Rural, Bonhomme Twshp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sycamore Drive,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether
In this community 8 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County ST. LOUIS Co.
(c) City or town RURAL ROUTE
(If outside city or town limits, write "RURAL")
(d) Street No. CHESTERFIELD, MO.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARY A. MILLER

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Rev. Henry Miller,

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

7. Birth date of deceased Mar. (Month) 30, (Day) 1856 (Year)

8. AGE: Years 89 Months 6 Days 26 If less than one day hr. min.

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

10. Usual occupation Retired housewife

11. Industry or business Own home

MOTHER FATHER
12. Name ? Kits,
13. Birthplace Unknown (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) 0 (State or foreign country)

16. (a) Informant Mrs. Tom. Bunte,
(b) Address Chesterfield, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Owensville, Mo.

18. (a) Signature of funeral director Schrader Funeral Home,
(b) Address Ballwin, Mo.

19. (a) 10-29-45 (Date received local registrar) (b) E. S. McGavran M. D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 26 year 1945 hour 8:45 minute P. M.

21. I hereby certify that I attended the deceased from July 1 1944, to OCT. 26 1945; that I last saw her alive on OCT. 25 1945; and that death occurred on the date and hour stated above.

Immediate cause of death CARONIC MYOCARDITIS

Due to ARTERIOSCLEROSIS 9 3d

Due to SENILITY

Other conditions NONE
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature B. R. Loving (M. D. or other) MD
Address Ballwin, Mo. Date signed 10-26-45

(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 Theo. Schrader

Licensed Embalmer No. 3066

P. O. Address Ballwin, Mo.

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.