

1-17-39
X36671

FILED JAN 25 1946

Registration District No. **318** Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial

(d) Length of stay: In hospital or institution _____
4 Days (Specify whether _____)

In this community _____
4 Days (years, months or days)

3. (a) PRINT FULL NAME JOSEPHINE MILLER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female / 5. Color White / 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased April 14 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joseph Retz

13. Birthplace France 5
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 5
(City, town, or county) (State or foreign country)

15. Birthplace France 5
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Hauck

(b) Address 2818 Pennsylvania

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1946
(Month) (Day) (Year)

(c) Place: burial or cremation Old S. S. P. & Paul Cem.

18. (a) Signature of funeral director The Retz Co.

(b) Address 2806 Gravois

19. (a) JAN 16 1946 (Date received local registrar) J. F. Brudeau (Registrar's signature)

2. USUAL RESIDENCE OR DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis, Mo., 2417
(If outside city or town limits, write "RURAL")

(d) Street No. 2818 Pennsylvania
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14th
year 1946 hour 10:50 minute A M.

21. I hereby certify that I attended the deceased from 1/10/46
_____ 19____ to 1/14/46 19____

that I last saw him alive on 1/14/46 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Cardiac decompensation 7 days Duration

Due to Arteriosclerotic heart disease ?

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 C. E. Mally 1/14/46
(City or town) (Date signed)

Address _____ Date signed _____

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

2874

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 *David Van Fossan*

Licensed Embalmer No. *4242*

P. O. Address *2906 Dunwoody*

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. 318

Primary Registration District No. 1003

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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Josephine Miller

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

4. Sex F 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 as (Month) (Day) (Year)

8. AGE: Years Months Day If less than one day
7k 9 14 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER

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) (Date received local registrar) (b) J. F. Brebeck (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 Feb Year 1945 hour 12 minute 00 M.

21. I hereby certify that I attended the deceased from 9 to 9, 1945; that I last saw him alive on 9, 1945; 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)

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

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)

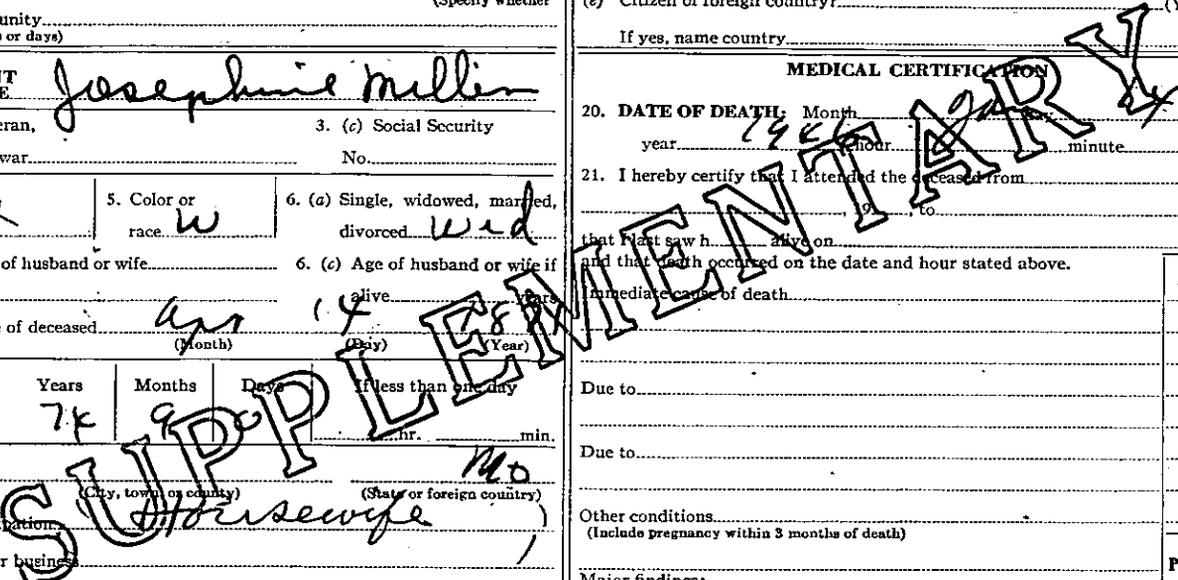
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

2874 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD



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