

S. No. 2  
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7-5-17-39  
X35497

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** MAR 2 1946  
Registration District No. 17

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7137  
State File No. \_\_\_\_\_  
Registrar's No. 493

Primary Registration District No. 6076

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Koch Hospital 0  
(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) 33

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5332 Ridge Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Paul C. Miller

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month February day 23rd  
year 1946 hour 8 minute \_\_\_\_\_ P.M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

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

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

7. Birth date of deceased July 23 1909  
(Month) (Day) (Year)

Pulmonary Tuberculosis

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>7</u>		hr. _____ min. _____

Due to \_\_\_\_\_  
Due to 164d

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Clerk

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry or business Emerson Electric

Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

12. Name Robert D. Miller

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

14. Maiden name Dora Carper

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

16. (a) Informant Robert D. Miller  
(b) Address 5332 Ridge Ave.

17. (a) Burial (b) Date thereof 2 - 27 - 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Cemetery

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Suicide  
(b) Date of occurrence 2/22/46  
(c) Where did injury occur? Neck  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Hospital  
(Specify type of place)  
While at work? \_\_\_\_\_ (f) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director James H. Stuart  
(b) Address 225 Union Blvd  
19. (a) 2-26-46 (b) ES M. Dorman  
(Date received local registrar) (Registrar's signature)

23. Signature Samuel E. Eubank (M.D. or other) \_\_\_\_\_  
Address Koch, Mo. Date signed 2/26/46

707

MAR 4 1945

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**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.....

Licensed Embalmer No.....

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.**