

FILED MAR 1 1948
318

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

1003

Registrar's No.

1653

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1-day
In this community _____
years, months or days

3. (a) PRINT FULL NAME William G. 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 M.

6. (b) Name of husband or wife Nellie Miller 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased March 29th., 1877
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Rec. Clerk, Stewart Auto Co

11. Industry or business _____

MOTHER FATHER { 12. Name Hy. Miller
13. Birthplace Germany
14. Maiden name Louise Spelbrink
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Miller
(b) Address 6188 McPherson Ave.

17. (a) Burial (b) Date thereof 2-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery
18. (a) Signature of funeral director Arthur J. Honnelly
(b) Address 3840 Lindell Blvd

19. (a) FEB 18 1948 (b) _____
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(d) Street No. 6188 McPherson Ave.
(If outside city or town limits, write "RURAL")
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16th.,
year 1946 hour 8 minute 45 p. M.

21. I hereby certify that I attended the deceased from 2-16-46, 19____ to 2-16-46, 19____
that I last saw him alive on 2-16-46, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis
Due to _____

Other conditions _____
(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?

While at work _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address 5899 Delmar Date signed 2/18/46

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

6689

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 W Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.