

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 27 1946
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18720**
Registrar's No. **4467**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4228 Norfolk Ave /
(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 **Robert Miller**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Grayce** 6. (c) Age of husband or wife if alive **62** years
7. Birth date of deceased **Sept 15 1867**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 8 2 hr. min.

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

10. Usual occupation **Section Foreman**

11. Industry or business **Mo Pacific Railroad**

12. Name **Robert Miller**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Grayce Miller**
(b) Address **4228 Norfolk Ave**
17. (a) **Burial** (b) Date thereof **5 20 46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park Cemt**

18. (a) Signature of funeral director **Kriegshauser**
(b) Address **4228 So Kingshighway**

19. (a) **MAY 18 1946** (b) **J. F. Bricker**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4228 Norfolk Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **17**
year **1946** hour **2.30 AM** minute _____ M.

21. I hereby certify that I attended the deceased from **Feb. 5** to **May 17**
that I last saw him alive on **May 16** and that death occurred on the date and hour stated above.

Immediate cause of death: **Pneumatic Endocarditis**

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

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 _____

Signature **J. F. Bricker** (M. D. or other) **Dr. J. F. Bricker**
Address **1446 So. Grand** Date signed **5/17/46**

Dr De Pau

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.....

Edwin S Mc Dermott

Licensed Embalmer No.....

3024

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.