

**FILED JUN 20 1946**  
Registration District No. **318**

Primary Registration District No. **1003**

State File No. \_\_\_\_\_

Registrar's No. **5189**

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:  
**Deaconess Hospital**  
(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 **BESSIE TOWNSEND MILLER.**  
FULL NAME

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Edward T. Miller.** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **July 4 1879**  
(Month) (Day) (Year)

8. AGE: **66** Years Months **11** Days **5** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **At home**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Townsend.**  
13. Birthplace **unknown** (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name **unknown**  
15. Birthplace **unknown** (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant **Townsend-Miller.**  
(b) Address **6820 Delmar Blvd.**  
17. (a) **Entombment** (b) Date thereof **6-11-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Oak Grove Mausoleum.**

18. (a) Signature of funeral director **C.R. Lupton & Sons.**  
(b) Address **7233 Delmar Blvd.**

19. (a) **JUN 11 1946** **J. F. Budeck** (Registrar's signature)  
(Date received local registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **University City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Castlereagh ; 6820 Delmar Blv**  
(If rural, give location) **NR**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **9**  
year **1946** hour **6:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **March 31 1946**, to **June 9 1946**  
that I last saw him alive on **June 8 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive heart failure** Duration **6 wks**

Due to **myocardial infarction**

Due to **chronic bronchitis** **2 1/2 mo**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PH

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) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature **Walter Lupton** (M. D. or other) \_\_\_\_\_  
Address **St. Louis Mo** Date signed **6/9/46**

WRITE PLAINLY—USE UNFADING INK—FURNISH FULL NAME OF REGISTRAR

JE 2866  
Hrs.

5189

**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 Clarence H. Murray  
Licensed Embalmer No. 4011  
P. O. Address St. Louis, 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.**

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.....  
years, months or days)

3. (a) PRINT FULL NAME *Bessie J. 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.....

7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years *66* Months Days If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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) (Data received local registrar) (b) *J. F. Brebeck*  
Date received local registrar.....

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..... day.....  
year *1946* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw him..... alive on....., 19.....  
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)

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..... (M. D. or other).....

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

**SUPPLEMENTARY**

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

JUN 28 1946

22028