

S. No. M-5-43
7-5-17-39
I X36871

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

24859

FILED JUL 30 1946
Registration District No. 217

Primary Registration District No. 6076

State File No. 0

Registrar's No. 1551

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
10014 Driver 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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 96
(c) City or town Overland 18
(If outside city or town limits, write "RURAL")
(d) Street No. 10014 Driver Ave. 5
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME ANGELINE MILLER
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 20
year 1946 hour..... minute..... M.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased 9-18-1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-1-1946 to 7-20-1946
that I last saw her alive on 7-19-1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
77 10 2 ..hr. ..min.

Immediate cause of death Acute Cardiac dilatation 1/2 hr.
Due to Myocarditis, Chronic
Due to Hypertensive Cardio-Vascular - Renal disease ?
Other conditions Diabetes mellitus ?
(Include pregnancy within 3 months of death)

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

PHYSICIAN
Major findings: None
Of operations.....
Of autopsy.....
Underline the cause to which death should be charged statistically.

11. Industry or business
12. Name Michael Pourcely
13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Isabelle unknown
15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Jones
(b) Address 4961 Highland Ave.
17. (a) Burial (b) Date thereof 7-23-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Olive Cem.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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?

18. (a) Signature of funeral director SULLIVAN'S BROTHERS
(b) Address 2849 North Euclid Ave.
19. (a) 7-23-46 (b) E. J. McFarlan
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature Nicholas J. Vitalone M. D. or other
Address 3861 St. Louis Ave. Date signed 7/20/46

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

36
1

207-113

Dr. Vitale

FR 1/1/83

3861 St Louis

Residence

7276 Ravinia

MM 1681

1 pm -

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

Robert L Brinkman

Licensed Embalmer No. 3553

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. AugRegistration District No. 217 Primary Registration District No. 6076 Registrar's No. 1551

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Overland
(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 Angelina 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 W

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

7. Birth date of deceased Sept 18
(Month) (Day) (Year)8. AGE: Years 77 Months _____ Days _____ (Unless than one day) hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 2849 N. Euclid St. Louis19. (a) 8-5-46 (b) Esmeralda
(Date received local registrar) (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 _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____

that I last saw h _____ 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 _____

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

24859