S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 28 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35415

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 8887

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:
4270a West Finney Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 21 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4270a West Finney Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William D. Miller

3. (b) If veteran, name war

3. (c) Social Security No. Lost

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frankie Miller

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased June 19 (Month) 1880 (Day) (Year)

8. AGE: Years 66 Months 3 Days 26 If less than one day hr. min.

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

10. Usual occupation Chef Peoples Hospital

11. Industry or business

FATHER
12. Name William Miller
13. Birthplace Unavailable (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unavailable
15. Birthplace Unavailable (City, town, or county) (State or foreign country)

16. (a) Informant Frankie Miller
(b) Address 4270a West Finney Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-46 (Month) (Day) (Year)
(c) Place: burial or cremation St Peter's Cemetery

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Avenue

19. (a) OCT 17 1946 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 15 year 1946 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from June, 1946 to Oct 15, 1946 that I last saw him alive on Oct 14 1946, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation — 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 J. A. Haskell (M. D. or other)
Address 4270a West Finney Avenue Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

Thomas J. Gates, Registered Apprentice No.,

working under my personal supervision.

Signed Thomas J. Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.