

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11962

FILED APR 3 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 718

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch, Mo

(c) Name of hospital or institution: Koch Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 451 Days

(Specify whether in this community _____ years, months or days) 451 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis

(If outside city or town limits, give "RURAL") 9

(d) Street No. 1620 A (If rural, give location) (HETTNU)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME CHARLES GILBERT MILEY

3. (b) If veteran, name war? ?

3. (c) Social Security No. ?

4. Sex Male Color NEGRO

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

6. (b) Name of husband or wife JESSIE COLLIER

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

7. Birth date of deceased: 12 25 94

(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 17

year 47 hour 9 minut 45 A.M.

21. I hereby certify that I attended the deceased from 12-21, 1945 to 3-17, 1947.

that I last saw him alive on 3-17, 1947 and that death occurred on the date and hour stated above.

8. AGE: Years 52 Months 2 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Kansas City, Mo

(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

Immediate cause of death Chronic Pulmonary tuberculosis heart eyes?

Due to _____

Due to _____

Other conditions Chronic bronch. Asthma

(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name William Miley

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name Etta Jackson

15. Birthplace _____

(City, town, or county) (State or foreign country)

16. (a) Informant Hosp. Records

(b) Address Koch Hosp Koch, Mo

17. (a) (Burial, cremation, or removal) _____

(b) Date received 3-19-47

(Month) (Day) (Year)

(c) Place: burial or cremation St James

18. (a) Signature of funeral director W. Richter

(b) Address 3500 Rutledge

19. (a) 3-29-47 (Date received local registrar)

(b) Ruth J. Allen (Registrar's signature)

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Beyard Friedman (M. D. or other) M. D.

Address Koch Hosp Koch, Mo Date signed 3-12-47

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

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.....

Licensed Embalmer No.....

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.