S. No. 2
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

39983

State File No. 11171

FILED DEC 15 1947

Registration District No. 718 — Primary Registration District No. 100 — Registrar's No.

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: Homer G Phillips Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL")
(d) Street No. 918 N Theresa (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lula Miller
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Femle
5. Color or race Col
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 15th (Day) 1895 (Year)
8. AGE: Years 52 Months 7 Days 17 If less than one day hr. min.
9. Birthplace Mont Sterling (City, town, or county) Ky (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name William Taylor
13. Birthplace Lex (City, town, or county) Ky (State or foreign country)
MOTHER 14. Maiden name Manda Cooper
15. Birthplace Sharpburg (City, town, or county) Ky (State or foreign country)
16. (a) Informant Elizabeth Rice
(b) Address 21 Olive Apt 5 Dayton Ohio
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-47 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood
18. (a) Signature of funeral director J. H. Randle & Son
(b) Address 3133 Bell ave
19. (a) DEC 6-1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 2 year 1947 hour 8 minute 15 a M.
21. I hereby certify that I attended the deceased from Nov. 30, 1947, to Dec. 2, 1947; that I last saw her alive on Dec. 2, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial Failure with Pulmonary Congestion -Chronic	Undet.
Due to	
Due to	
Other conditions: None (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Oscar L. Daniels (M. D. or other)
Address 2601 N Whittier Date signed 12/3/47

Jefferson City Printing Co.
(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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed L. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Chouteau

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.

S. No. 2D
M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dee

Registration District No. 318 Primary Registration District No. 003 Registrar's No. 11171

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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Lula Miller

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April 15 (Month) (Day) (Year)

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

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

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name

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

MOTHER

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) (Date received local registrar) (b) J. F. Bredick (Registrar's signature) DEC 27 1937

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1937 hour minute M.

21. I hereby certify that I attended the deceased from , 19 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

39983