FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 14 1948
Registration District No. 377

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 21742

Registrar's No. 1557

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch (rural) (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1044 days (Specify whether years, months or days)

In this community 28 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. 1821a South Jefferson (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MILLER, JOHN HARVEY

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

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 March (Month) 28 (Day) 1872 (Year)

8. AGE: Years 76 Months 2 Days 22 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

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

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

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6-23-48 (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director O W McLaughlin

(b) Address 2301 Lafayette Ave

19. (a) 6-23-48 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 19 year 1948 hour 10 minute 00 P.M.

21. I hereby certify that I attended the deceased from 8-10-45, 19, to 6-19-48, 19; that I last saw him alive on 6-19-48, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	21 yrs. (??)
Due to 13 b	
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 John W. Beckham (M. D. or other)

Address Robt. Koch Hospital Date signed 6-21-48

(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 C W Cooper

Licensed Embalmer No. 3836

P. O. Address 2301 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.