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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41677**
Registrar's No. **11070**

FILED JAN 11 1949 **318**
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3218 Lawton 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 St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3218 Lawton Ave.
21 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME Eli Miles
3. (b) If veteran, name war Yes 3. (c) Social Security No. 452-16-0018

4. Sex Male 2, 5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margie Miles 6. (c) Age of husband or wife if alive 25 years
7. Birth date of deceased June 4, 1916
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 6 15 hr. min.

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

10. Usual occupation Cook

11. Industry or business _____

MOTHER, FATHER { 12. Name Eli Miles
13. Birthplace Monroe, La
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Hardy
15. Birthplace Monroe, La.
(City, town, or county) (State or foreign country)

16. (a) Informant Johnnie Miles
(b) Address 3705 a. Windsor Pl.

17. (a) Burial (b) Date thereof 12/23/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director C.W. Roberts
(b) Address 1416 N. Taylor Ave

19. (a) DEC 22 1948 (b) J. B. Lesater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19
year 1948 hour 11 minute 11 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 _____
Death of Brain
Alcoholic
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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) _____
(e) Means of injury _____
23. Signature [Signature] (M.D. or other) _____
Address _____

JAN 18 1949

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.....

James Carter....., Registered Apprentice No. 290
working under my personal supervision.

Signed Fulton E. Culkin.....

Licensed Embalmer No. 498.....

P. O. Address Meriden 13, Conn.

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.