

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 19 1949

State File No. **3039**
Registrar's No. **310**

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY None				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY SAINT LOUIS			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Saint Louis		c. LENGTH OF STAY (in this place) 65 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS		d. STREET ADDRESS (If rural, give location) 4454 ENRIGHT	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4454 Enright Avenue				3. NAME OF DECEASED a. (First) MARY b. (Middle) ELLA c. (Last) MILLER			
4. DATE OF DEATH Jan 10 1949		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 1-15-1852		9. AGE (In years, last birthday) 96		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Cadiz, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unavailable		13b. MOTHER'S MAIDEN NAME Unk	
14. NAME OF HUSBAND OR WIFE Sylvester (decd)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Joan B. Miller, 4454 Enright	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral insufficiency ANTECEDENT CAUSES Dropsey Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Sept 11, 1948 , to Jan. 10, 1949 , that I last saw the deceased alive on Jan. 10, 1949 , and that death occurred at 7 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE J. B. Lassiter (Degree or title) M.D.				23b. ADDRESS 1005 N. Leffingwell Ave		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE JAN. 12, 1949		24c. NAME OF CEMETERY OR CREMATORY Saint Peters Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. JAN 11 1949		REGISTRAR'S SIGNATURE J. B. Lassiter		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates, 8107 Finney Ave ADDRESS			

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. ~~4476~~ 4259

P. O. Address 4107 Finney Ave

St. Louis, Mo.

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.