

FILED SEP 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28904

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1951

1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Clayton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>	
c. LENGTH OF STAY (In this place) <u>3</u>		d. STREET ADDRESS (If rural, give location) <u>8015 Forsythe</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DOA St. Louis Co. Hosp.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Lemie</u>	b. (Middle)	c. (Last) <u>Miller</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 9, 1949</u>
--	-------------------------	-------------	-------------------------	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>unk. abt. 1880</u>	9. AGE (In years last birthday) <u>abt. 69</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
----------------------	-------------------------------	---	--	--	------------------------	-----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>	11. BIRTHPLACE (State or foreign country) <u>Fordyce Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>
---	---	---	---

13a. FATHER'S NAME <u>not known</u>	13b. MOTHER'S MAIDEN NAME <u>not known</u>	14. NAME OF HUSBAND OR WIFE <u>James Miller (deceased)</u>
-------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ida Harrison</u>	ADDRESS <u>8015 Forsythe Blvd.</u>
--	-------------------------------------	---	------------------------------------

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH  <u>4 1/2 X</u>
	ANTECEDENT CAUSES Morbidity 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.		

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 Jan 3, 1942 to Aug 3, 1949, that I last saw the deceased alive on Aug 3, 1949 and that death occurred at ? m., from the causes and on the date stated above.

23a. SIGNATURE <u>Franklin D. Karpis M.D.</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>1631 Franklin Ave</u>	23c. DATE SIGNED <u>Aug 12/1949</u>
---	-------------------------------	---------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8/13/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u>
---	----------------------------	---	--

DATE REC'D BY LOCAL REG. <u>8-13-49</u>	REGISTRAR'S SIGNATURE <u>Robert Blonke</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Gates</u>	ADDRESS <u>4107 Finney</u>
---	--	--	----------------------------

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

C-44

*[Handwritten signature]*

**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 *[Handwritten Signature]*

Licensed Embalmer No. *4259*

P. O. Address. *4407 7<sup>th</sup>*

**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.