

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32019**
8528
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | 2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. STREET ADDRESS (If rural, give location) 1129 a N. 19th Street | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Charley b. (Middle) _____ c. (Last) Miller | | 4. DATE OF DEATH (Month) (Day) (Year) 9 - 29 - 1949 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH May 3, 1887 |
| 9. AGE (In years last birthday) 62 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 2 HRS.: Hours _____ Min. _____ | | 11. BIRTHPLACE (State or foreign country) Boliver, Tenn. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME George Miller | | 13b. MOTHER'S MAIDEN NAME Rosie Simmons | |
| 14. NAME OF HUSBAND OR WIFE Emma Miller | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) _____ | |
| 16. SOCIAL SECURITY NO. 499-01-8010 | | 17. INFORMANT'S SIGNATURE OR NAME Emma Miller, 1129a N. 19th Street | |

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES DUE TO (b) Tubercular E. Sema DUE TO (c) Cardiac Hypertrophy II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aortic Regurgitation | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | |

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|---------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 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 St. Louis Missouri | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 4214 | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **9:40 P. m., from the causes and on the date stated above.**

| | | | |
|-------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|
| 23a. SIGNATURE Joseph M. [Signature] (Degree or title) | | 23b. ADDRESS 1300 Clark | |
| 23c. DATE SIGNED 10/11/49 | | 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 24b. DATE 10-5-1949 | | 24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery | |
| 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri. | | 25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home, 2820 Stoddard St. | |

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|------------------------------------------------------|--|------------------------------------------------------|--|
| DATE REC'D BY LOCAL REG. OCT 4 1949 | | REGISTRAR'S SIGNATURE J. B. Pasater | |
|------------------------------------------------------|--|------------------------------------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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 Eulster E. Culkin

Licensed Embalmer No. 4198

P. O. Address St Louis 13, 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.