

FILED NOV 3 1950

STANDARD CERTIFICATE OF DEATH

State File No. 35134
9109

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 70 Yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2159				
d. FULL NAME OF HOSPITAL OR INSTITUTION 540 Eiler Avenue				d. STREET ADDRESS (If rural, give location) 540 Eiler Avenue				
3. NAME OF DECEASED (Type or Print) a. (First) Lawrence b. (Middle) E c. (Last) Miller			4. DATE OF DEATH (Month) (Day) (Year) Oct. 26, 1950					
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH March 16, 1869		9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Municipal Transportation		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Christ Miller			13b. MOTHER'S MAIDEN NAME Susan Lieser		14. NAME OF HUSBAND OR WIFE Anna Marie Schultz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Anna Miller, 540 Eiler Avenue				
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralysis of Respiratory Center ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Nephritis DUE TO (c) Carcinoma of Prostate II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 6 months 5 years	
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 177X				
22. I hereby certify that I attended the deceased from June, 1945, to Oct. 25, 1950, that I last saw the deceased alive on Oct. 25, 1950, and that death occurred at 7:45 a.m., from the causes and on the date stated above.								
23a. SIGNATURE Ellis L. Pollock M.D. (Degree or title)				23b. ADDRESS 3450 Gravois		23c. DATE SIGNED 10/26/50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 28, 1950	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
DATE REC'D BY LOCAL REG. OCT 27 1950		REGISTRAR'S SIGNATURE J. B. Larson		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.				

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Ellis L. Pollock,
3450 Gravois

Res. 3958 Avenue K

1:00 - 4:00 Daily Except Thursday
7:00 - 8:30 Evening. Mon. Wed. Fri.

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed

Max L. Warfel

Licensed Embalmer No. *4170*

P. O. Address *1936 St Louis*

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.