N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D MAY 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791

13074
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 3416

(c) or City St. Louis (d) Street No. 4932 Fountain Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 71 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 460 Louisa Miller

(a) Residence, No. 4932 Fountain Ave. St. 12
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow of Walter P. Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 23, 1868

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
71	2	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
9. Industry or business in which work was done, as saw mill, bank, etc. At Home
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

FATHER

13. NAME John Frein
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

MOTHER

15. MAIDEN NAME Gertrude Roeser
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

17. INFORMANT (ADDRESS) Josephine Roesner 4711 Thrush Ave.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cem. DATE 4/13/39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. W. McLaughlin 2301 Lafayette Ave.

20. FILED ....., 19 J. F. Budeck Local Registrar.

APR 12 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1938, to Mar 25, 1939
I last saw her alive on Mar 25, 1939 Death is said to have occurred on the date stated above, at 1 AM.
The principal cause of death and related causes of importance were as follows:

Chr Myocarditis

Date of onset

Other contributory causes of importance:
Chr. Arterial Hypertension

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) A. W. Schumacher, M. D.
(Address) 4981 Thrush

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Paul A. Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayett

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.