

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

791  
1008  
17374  
Do not use this space.  
4908

1. PLACE OF DEATH <sup>6500 ANN 1 230</sup> 3  
 (a) County St. Louis Registration District No. 1008  
 (b) Township St. Louis Primary Registration District No. 4908  
 (c) City St. Louis (d) Street No. On Route Home Phillips St.  
 (e) Length of residence in city or town where death occurred yrs mos. ds. (f) How long in U.S., if of foreign birth? yrs mos. ds.  
 2. PRINT FULL NAME Lillie Miller (w)  
 (a) Residence, No. 2633 1/2 Market St. St. 21 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 4. COLOR OR RACE Unknown  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
abt 33  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unknown  
 9. Industry or business in which work was done, as saw mill, bank, etc. Unknown  
 10. Date deceased last worked at this occupation (month and year) Unknown  
 11. Total time (years) spent in this occupation Unknown  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.  
 13. NAME Unknown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "  
 15. MAIDEN NAME "  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

17. INFORMANT (ADDRESS) Robert O'Keefe - D.D. 3123 Cahoy  
 18. BURIAL, CREMATION OR REMOVAL PLACE DATE Washington 5/10/39  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Washington 3123 Cahoy  
 20. FILED J. B. Brubaker  
 19 39  
**MAY 31 1939**

**MEDICAL CERTIFICATE OF DEATH**  
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/25 1939  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.  
 I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Hemorrhage into Left Lung, Ruptured Vessel of Left Lung.  
 Other contributory causes of importance: Cont. labor  
 Name of operation 1146 Date of \_\_\_\_\_  
 What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy Yes  
 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) Joseph M. Green, M.D.  
 (Address) Georgetown, Pa.

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**