

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME William Glenn Miller

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 10 1926  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
13 11 4 hr. min.

9. Birthplace Tampa Florida  
(City, town, or county) (State or foreign country)

10. Usual occupation School Student

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Clarence Miller

13. Birthplace Terre Haute Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Duncan

15. Birthplace ZCole City Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Miller

(b) Address 1528 No. 10th. St.

17. (a) Removal (b) Date thereof 8-15-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Albert Hoppe

(b) Address 4700 Washington Ave.

19. (a) AUG 14 1940 (b) J. B. Budick  
(Date received from registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 26  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1528 No. 10 St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14<sup>th</sup> 1940  
year \_\_\_\_\_ hour 8 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from May 18<sup>th</sup> 1940, to Aug 14<sup>th</sup> 1940  
that I last saw him alive on Aug 13<sup>th</sup> 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis  
ing strep sore throat  
Due to Infected sore throat  
strep non diphtheretic

Other conditions ✓  
(Include pregnancy within 3 months of death)

Major findings: ✓ 115  
Of operations \_\_\_\_\_  
Of autopsy ✓

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No  
(b) Date of occurrence ✓  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Robert Lewis (M. D. or other)  
Address 990 Olive St. Date signed 8/14/40

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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 *J. S. Sullivan*

Licensed Embalmer No... *1122* .....

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, fact should be so stated above.**