

DEC 22 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

36922

State File No. ....

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **9152**

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:  
**BARNES 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

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County MADISON  
(c) City or town GRANITE CITY  
(If outside city or town limits, write "RURAL.")  
(d) Street No. 2037 BUXTON  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_  
(Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 16  
year 1941 hour 1 minute 05 P. M.

21. I hereby certify that I attended the deceased from NOVEMBER 7, 1941, to NOVEMBER 16, 1941;  
that I last saw him alive on NOVEMBER 16, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Lymphosarcoma with widespread metastases  
Duration 2-4 mos

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Lympho sarcoma with widespread metastases  
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) \_\_\_\_\_  
(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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature Remellon Sale M. D. or other \_\_\_\_\_  
Address BARNES HOSPITAL Date signed 11-16-41

3. (a) PRINT FULL NAME ROBERT DYMOND MILLER

3. (b) If veteran, name war No. 3. (c) Social Security No. Unknown

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

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

7. Birth date of deceased Nov. 21 1921  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
19 11 25 hr. \_\_\_\_\_ min.

9. Birthplace Granite City Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Truck Driver

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

12. Name Floyd R. Miller

13. Birthplace Texas  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Briggs

15. Birthplace Jerseyville Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Floyd Miller

(b) Address Granite City, Ill.

17. (a) Removal (b) Date thereof 11-18-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Granite City, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) NOV 18 1941 (b) J. F. Budick  
(Date received local registration) (Registrar's signature)

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

1941

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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. W. Binkley*

Licensed Embalmer No. ....

*3653*

P. O. Address.....

*St. Louis, 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.**