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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 14 1945
318

State File No. _____
Registrar's No. 7745

Registration District No. _____ Primary Registration District No. 1003

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: Christian Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0007
(c) City or town St. Louis 177
(If outside city or town limits, write "RURAL")
(d) Street No. 5453 Claxton Ave 9
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Louise Miller
(b) If veteran, name war None
(c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John M. Miller
6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased May 2, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 4 0 hr. min.

9. Birthplace Unknown France
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER {
12. Name Unknown
13. Birthplace Unknown France
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown France
(City, town, or county) (State or foreign country)

16. (a) Informant John M. Miller
(b) Address 5453 Claxton Ave

17. (a) Burial (b) Date thereof 9/5/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

19. (a) SEP 4 1945 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2,
year 1945 hour 11:15 AM minute _____ M.
21. I hereby certify that I attended the deceased from 1940
19 _____ to Sept 2 1945
that I last saw her alive on Sept 2 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-vascular renal disease

Due to _____
Due to 131

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

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature J. F. Bredeek (M. D. or other) M. D.
Address 5074 N. Union Date signed 9-4-45

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

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 *Gustav W. Dietel*

Licensed Embalmer No. *4329*

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.