

FILED APR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11344

State File No.

| | | | | | | | |
|--|-------------------------------|---|--|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>317</u> | | PRIMARY REG. DIST. NO. <u>3063</u> | | Registrar's No. <u>747</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>Clayton</u> | | c. LENGTH OF STAY (in this place) <u>1 DAY</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Robertson</u> | | 4000 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Co. Hospital</u> | | | | d. STREET ADDRESS (If rural, give location) <u>Route # 1</u> | | | |
| 3. NAME OF DECEASED a. (First) <u>ARTHUR</u> | | b. (Middle) <u>B.</u> | | c. (Last) <u>MILES</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>March 20 1950</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>Nov 8 1892</u> | | 9. AGE (In years last birthday) <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13a. FATHER'S NAME <u>? Miles</u> | | 13b. MOTHER'S MAIDEN NAME <u>Emma Insul</u> | | 14. NAME OF HUSBAND OR WIFE <u>May Miles</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>497-07-3226</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>May Miles Route 1 Robertson Mo.</u> | | | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>443X</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11:30 AM 3-20-50</u> | | 21e. INJURY OCCURRED WHILE AT WORK? <input checked="" type="checkbox"/> NOT WHILE AT WORK? <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>3-20-1950</u> , to <u>3-20-1950</u> , that I last saw the deceased alive on <u>3-20-1950</u> and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>R. P. Coble, M.D.</u> (Degree or title) | | | | 23b. ADDRESS <u>601 Brentwood, Clayton</u> | | 23c. DATE SIGNED <u>3-20-50</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>March 23 1950</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u> | | 24d. LOCATION (City; town, or county) (State) <u>St. Louis Co. Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>3-22-50</u> | | REGISTRAR'S SIGNATURE <u>Robert H. Blomke</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos. W. Clark 1125 Hodiamont Ave</u> | | | |

Hood

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

J. Wm 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.