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

Do not use this space.

8213

1. PLACE OF DEATH

County ..... Registration District No. 78..

Township ..... Primary Registration District No. 1003

City St. Louis Mo (No. 813 S-18 ..... St. ..... Ward)

File No. .....

Registered No. 1862

2. FULL NAME John Milan

(a) Residence No. 813 South 18 St., 22 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
X HUSBAND OF (OR) WIFE OF Roberta Milan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 4/1872

7. AGE: 56 YEARS | 9 MONTHS | 2 DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT Roberta Milan
(Address) 813 South 18th St.

15. FILED FEB -8 1929 19 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 6 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7 30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ch Myocarditis 92 A
93 C
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Ch. Endocarditis
H. M. A. (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. W. Keene, M.D.
2/7, 1929 (Address) Dep Corone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Greenwood Cemetery
DATE OF BURIAL: 2/11 1929

20. UNDERTAKER: Dunn Bros.
ADDRESS: 215 S. Jeff Ave

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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