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

Do not use this space.

12659

791
1003

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 3193

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Fred Millian

(a) Residence. No. 2219 Market St., 21 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 28, 1904

7. AGE: Years 25 | Months 1 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Chauffer
(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) La.

PARENTS

10. NAME OF FATHER Adam Millian

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) La.

12. MAIDEN NAME OF MOTHER Juanita Nelson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) La.

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED 11 1/23 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-2- 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-25-, 1929, to 3-2-, 1929 that I last saw him alive on 3-2-, 1929, and that death occurred, on the date stated above, at 6:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

108 1018

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) .....

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? X ray

(Signed) T. E. Cunningham, M. D

, 19 (Address) 2945 Lawton

*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: Washington Park
DATE OF BURIAL: 3/14/1929

20. UNDERTAKER: J. W. Hughes
ADDRESS: 2620 Lawton

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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