

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

Do not use this space.

42488
12221

1. PLACE OF DEATH

County.....
Township.....
City St. Louis, Mo. (No.)

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No.
St. Ward)

ISOLATION HOSPITAL

2. FULL NAME

Flora Mills
(a) Residence. No. 3435 Pine St. St. 19 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 30 yrs. 7 mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt. 1869.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 60 Unknown ? ? ?

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

9. BIRTHPLACE (CITY OR TOWN) West Salem Ill.
(STATE OR COUNTRY)

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Soraine Kroner
(Address) ISOLATION HOSPITAL

15. FILED 8241 EX 227 Next E. St. Mary
19 19 REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-12 19 29
17. I HEREBY CERTIFY, That I attended deceased from 11-12, 19 29 to 12-12, 19 29 that I last saw he alive on 12-12, 19 29 and that death occurred, on the date stated above, at 5:20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
930 (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
(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) R. K. K. K. M. D.

12-13, 19 29 (Address) ISOLATION HOSPITAL
*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 Bellefontaine Cemetery DATE OF BURIAL 12-16 19 29

20. UNDERTAKER Wm J. Robert ADDRESS 1905 S. Grand Blvd

Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE MUST BE CAUSE OF DEATH in plain terms, so that it may be properly classified.

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