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.

OCT 23 1935

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

Do not use this space.

791

31083

1003

File No.

Registered No. 7878

1. PLACE OF DEATH

County

Township

City St Louis (No. City Hosp #1 St. Ward)

Registration District No.

Primary Registration District No.

2. FULL NAME 49496 Millie Philbrick

(a) Residence, No. 2542 St., Arlington Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. 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: Sam Philbrick

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 20, 1854

7. AGE: Years 81 | Months 1 | Days 27 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Hwk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

FATHER

13. NAME: Wm Stapleton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ky.

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Hosp Inf Mt Kent City Hosp #1

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Peters Cem. DATE Sept. 20, 1935

19. UNDERTAKER (ADDRESS): Drehmann Naval 1905 Union Blvd

20. FILED SEP 19 1935 19 J F Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Sept 17, 1935

22. I HEREBY CERTIFY, That I attended deceased from 9/15, 1935, to Sept 17, 1935. I last saw her alive on Sept 17, 1935. Death is said to have occurred on the date stated above, at 12 35 m.

The principal cause of death and related causes of importance were as follows:

Atrophic Arthritis
Senility

107a

Date of onset

Other contributory causes of importance:
Bronchi-pneumonia

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) [illegible] M. D.

(Address) City Hosp #1