

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. **103** Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.

(c) Name of hospital or institution: 3339 Wisconsin Ave.

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME 465 Mary Jane Milliron

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased May 29 1870

8. AGE: Years 69 Months 5 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Adams Co., Ohio

10. Usual occupation Housewife

11. Industry or business _____

12. Name Marion Bacon

13. Birthplace Adams Co., Ohio

14. Maiden name Mary Burley

15. Birthplace Adams Co., Ohio

16. (a) Informant's own signature Chas. Clitterbaugh

(b) Address 3339 Wisconsin

17. (a) Removal (b) Date thereof 11/20/39

(c) Place: burial or cremation St. Clair, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) NOV 20 1939 4300 Washington Ave.

19. (a) _____ (b) J. J. Bredbeck

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County NR

(c) City or town St. Clair

(d) Street No. _____

(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18 year 1939 hour 9 minute 02 P. M.

21. I hereby certify that I attended the deceased from 9-2-39 _____, 1939, to 11-18 _____, 1939;

that I last saw her _____, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____

(e) Means of injury _____

23. Signature O. J. Jones (M. D. or other) MP

Address 3616 S. Brady Date signed 11-20

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. B. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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, above space should be left blank.