

Registration District No. **318**

Primary Registration District No. **1003**

6873

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Park Lane Memorial Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Wayne
 (c) City or town Wayne City
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Lula Milner
 3. (b) If veteran, name war Nil
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 29
 year 1943 hour 4 minute 9 M.

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Logan Milner
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased December 29 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 1, 1943, to July 29, 1943
 that I last saw him alive on July 29, 1943
 and that death occurred on the date and hour stated above.
 Immediate cause of death chronic myocarditis
myocarditis
 Duration _____

8. AGE: Years 49 Months 7 Days 0
 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Johnsonville Illinois
(City, town, or county) (State or foreign country)
 10. Usual occupation Teacher
 11. Industry or business School
 12. Name John Lowe
 13. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name Adella Robinson
 15. Birthplace Springfield, Illinois
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mable Schalcher
 (b) Address Christopher Illinois
 17. (a) Removal (b) Date thereof 7/29/43
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wayne City, Illinois
 18. (a) Signature of funeral director Albert H. Hoppe, Inc
 (b) Address 4700 Washington Blvd
 19. (a) III 29 1943 J. F. Busch
(Date received local registrar) (Registrar's signature)

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 T. J. [unclear] (M. D. or other)
 Address 4507 [unclear] Date signed 8/2/43

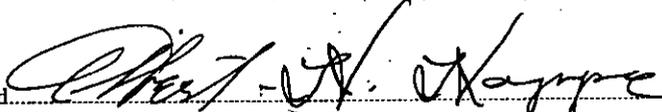
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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..... .....

Licensed Embalmer No. 1861.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6873

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

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

In this community _____ (Specify whether)

years, months or days

3. (a) PRINT FULL NAME Lula Milner

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex _____

5. Color or race _____

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE:	Years	Months	Days	If less than one day
				hr. min.

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-16-43 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Wayne

(c) City or town Wayne City
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 29
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S. 23288