

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43892**

FILED JAN 10 1944

Registration District No. **319**

Primary Registration District No. **4468**

Registrar's No. **64**

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

1. PLACE OF DEATH:

(a) County ST. GENEVIEVE

(b) City or town ST. MARY'S
(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 _____ years, months or days

3. (a) PRINT FULL NAME MARY IDA MILLS

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 ROBERT H. MILLS **6. (c) Age of husband or wife if** 65 years
alive _____ years

7. Birth date of deceased DEC 10 1878
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|----------|----------------------|
| <u>65</u> | <u>0</u> | <u>8</u> | hr. _____ min. |

9. Birthplace PERRY CO MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name HENRY L. TUCKER

13. Birthplace PERRY CO MO
(City, town, or county) (State or foreign country)

14. Maiden name SUSAN LAYTON

15. Birthplace PERRY CO MO
(City, town, or county) (State or foreign country)

16. (a) Informant Robert H. Mills

(b) Address St. Mary's Mo

17. (a) Burial Coryville Mo **(b) Date thereof** Dec 21 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coryville Mo

18. (a) Signature of funeral director Geo. C. Baker

(b) Address St. Genevieve Mo

19. (a) _____ **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. **(b) County** St. Genevieve

(c) City or town St. Marys
(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 Dec day 18
year 1943 hour 9:15 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 1
_____ 1943, to Dec 18, 1943
that I last saw her alive on Dec 18, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-Vascular-Renal Disease **Duration** 3yrs.

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? _____ **(e) Means of injury** _____

23. Signature Arthur E. Simpson **(M.D. or other)** M.D.

Address St. Genevieve Mo **Date signed** 12-19-43

1310

RECEIVED

District Health Officer No. 4
District File Number 144-320
Date Filed 1-7-44

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

Geo. C. Bacher

Licensed Embalmer No. 1985

P. O. Address St. Lawrence Ave

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County St. Genevieve
(b) City or town Marion
(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 _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME

Mary J. Miles

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced on

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 65 year

7. Birth date of deceased Dec. 10 1865
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days _____ (If less than one day, _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 20/43 (b) T.W. Douglas
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Dec. day 10 year 1943 hour _____ minute _____ M.

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

Duration

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-43993