

FILED APR 1 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2881

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
7082 Bancroft 1  
(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) 1 Month

7. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis MO. 93  
(If outside city or town limits, write "RURAL")

(d) Street No. 7082 Bancroft  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lillie Minks

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 24  
year 1944 hour 3 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from  
3-22-1944 to 3-24-1944  
and that I last saw him alive on 3-24-1944  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Jason Minks 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased: (Month) 7 (Day) 1 (Year) 1916

Immediate cause of death  
Subacute bacterial endocarditis

Due to Streptococcus Jan 22 to Mar 24 1944

Due to viridans 1944

8. AGE: Years 26 Months 8 Days 24 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Moelle Mo (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Edw Stalman

13. Birthplace St. Clair Mo (City, town, or county) (State or foreign country)

14. Maiden name Sara Deaton

15. Birthplace St. Clair Mo (City, town, or county) (State or foreign country)

16. (a) Informant Jose Minks

(b) Address St. Clair Mo

17. (a) \_\_\_\_\_ (b) Date thereof 3 26 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moelle Mo

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

(b) Address 4700 Washington Blvd.

19. (a) MAR 28 1944 (b) J. F. Bridock  
(Date received local health officer's report) (Registrar's signature)

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 J. F. Bridock (M. D. or other) \_\_\_\_\_  
Address 3500 Cambridge Date signed 3/24/44

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

2881

2881

No Embalm

---

---

**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.....

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.**