

U.S. No. 2  
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Rev. 5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2812

FILED FEB 13 1945

Registration District No. 317 Primary Registration District No. 3069

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
St. Marys Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 3856 W. Florissant Ave.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Sharon Eileen Mills

3. (b) If veteran, name war No

3. (c) Social Security No. -----

4. Sex F. 5. Color or race W.

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

6. (b) Name of husband or wife \*\*\*

6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased Nov. 18, 1944  
(Month) (Day) (Year)

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

1	26	hr.	min.
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9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation -----

11. Industry or business -----

12. Name Marvin Mills

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

14. Maiden name Catherine Moran

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

16. (a) Informant Catherine Mills

(b) Address 3856 A W. Florissant Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive cemetery

18. (a) Signature of funeral director John G. Mondell

(b) Address 1926 Allen Ave.

19. (a) JAN 17 1945 (Date received local health officer) (b) E. H. McCaura (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14  
year 1945 hour 11 minute 00 P.M.

21. I hereby certify that I attended the deceased from December 15, 1945, to January 14, 1945;  
that I last saw her alive on January 14, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Branchopneumonia  
Internal Hydrocephalus  
Due to Congenital

Due to 1570

Other conditions Spina Lubida e meningococci  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Branchopneumonia, Hydrocephalus, Meningococci, Phlebotomy of Kidney

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 John S. Bennett M.D. (M. D. or other)  
Address 6780 Clayton Rd. Date signed 1/15/45

Duration 2da.  
since birth

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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 me

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

Signed Wm. C. Maynard

Licensed Embalmer No. 1467

P. O. Address 1926 Allen St

**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.