

FILED MAR 28 1945

Registration District No.

318

Primary Registration District No.

1003

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:
St. Anthony Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 2519 A S. Broadway
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

Lillie Mills

3. (b) If veteran,

No

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 Arthur Mills 6. (c) Age of husband or wife if alive. 55 years

7. Birth date of deceased May, 21, 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 9 30 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name William Hamon

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

14. Maiden name Unknown

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

16. (a) Informant Arthur Mills

(b) Address 2519 A S. Broadway

17. (a) removal (b) Date thereof 3/22/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau Mo.

18. (a) Signature of funeral director Wm E. Myrdell

(b) Address 1926 Allen Ave

19. (a) Mar 21 1945 (b) J. F. Bredich
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20
year 1945 hour 8 minute 45 P.A.M.

21. I hereby certify that I attended the deceased from Mar 20
18 to Mar 20, 1945
that I last saw h. w alive on Mar 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death coronary thrombosis

Due to arteriosclerosis

Due to 61

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy yes
as above

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) Means of injury.

23. Signature H. S. Lyne (M. D. or other) MD

Address 18630 Parkway Date signed 2/21/45

Duration

1 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen 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.