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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 13 1945

State File No. 29222

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8544

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: Homer. G. Phillips.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community (3) ThRee Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town ST. Louis 1722
(If outside city or town limits, write "RURAL")

(d) Street No. 214. So. Ewing Ave. 9
(If rural, give location)

(e) Citizen of foreign country? ✓ 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Leamon. Mc, Millon

3. (b) If veteran, name war None

3. (c) Social Security No. 498-20-1106

4. Sex Male 2

5. Color or race Col.

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

6. (b) Name of husband or wife Fannie. Mae. Mc, Millon

6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased 4 (Month) 8 (Day) 1918 (Year)

8. AGE: Years 27 Months 5 Days 23 If less than one day hr. min.

9. Birthplace Cotton Plant (City, town, or county) Ark. (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Laundry

FATHER 12. Name Oliver. Mc, Millon.

FATHER 13. Birthplace CottonPlant (City, town, or county) Ark. (State or foreign country)

MOTHER 14. Maiden name Deliah. Bagsby.

MOTHER 15. Birthplace CottonPlant (City, town, or county) Ark. (State or foreign country)

16. (a) Informant Fannie Mae McMillon

(b) Address 214. So. Ewing Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 5 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Brinkley. Ark.

18. (a) Signature of funeral director R C Houston Jr

(b) Address 2812 . Thomas. Street.

19. (a) OCT 3 1945 (Date received local registrar) (b) J. R. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1 year 1945 hour 8:15 minute a. M.

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

Immediate cause of death Chronic Interstitial Nephritis — Duration

Due to Chronic Hypertrophic Myocarditis

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? (Specify type of place)

While at work (e) Means of injury

23. Signature (M. D. or other)

Address Date signed 10/1/45

(Licensed Embalmer's Statement on Reverse Side)

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 Chas. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

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.