

U.S. No. 2
FORM-5-43
REV. 5-17-39
W I X36671

#20277
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35646**
10233
Registrar's No. _____

FILED DEC 7 1945
318

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether)

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. 4339 Gano Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME MARGARET MILLIGEN

3. (b) If veteran, name war No. 3. (c) Social Security No. None

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

6. (b) Name of husband or wife William Milligan 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Oct. 10 1883
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22nd
year 1945 hour 12:45 minute A M.

21. I hereby certify that I attended the deceased from 11/17/45
to 11/22/45, 19____, to 11/22/45, 19____,
that I last saw her alive on 11/22/45, 19____,
and that death occurred on the date and hour stated above.

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

62	1	12	hr. _____ min.
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Immediate cause of death
Generalized peritonitis
unknown etiology

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Generalized peritonitis
etiology unknown

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name Unknown Norman

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

14. Maiden name Unknown

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant William Milligan

(b) Address 4154 N. Prairie

17. (a) Cremation (b) Date thereof 11-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

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

(b) Address 4700 Washington Blvd.

19. (a) NOV 27 1945 (b) J. F. Bredich
(Date received by registrar) (Registrar's signature)

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 Albert H. Hoppe (M. D. by occupation) 11/23/45

Address City Hosp Date signed _____

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

10233

10233

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..... *Elna R. Redwell*.....
..... Licensed Embalmer No..... *4077*.....
..... 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.