

U. S. No. 2
FORM-8-13
Rev. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4181**
Registrar's No. **72**

Registration District No. **47**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution:
State Hosp. #1 21
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since Dec-11-1945
(Specify whether)

In this community 18 yrs.
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis ¹⁴

(c) City or town City of St. Louis ²
(If outside city or town limits, write "RURAL")

(d) Street No. 202 South 23rd ⁰
(If rural, give location)

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

3. (a) PRINT FULL NAME Harold Mills

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex male ²¹ 5. Color or race negro

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 Sept 5 1927
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13 year 1947 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from 12-11-1945 to Feb 13 1947; that I last saw him alive on Feb 12 1947; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>19</u>	<u>5</u>	<u>8</u>	_____ hr. _____ min.

Immediate cause of death massive acute bilateral pulmonary tuberculosis

Due to _____

Due to _____

9. Birthplace City of St. Louis Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

Other conditions toxic myocarditis and secondary anemia
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy as above

MOTHER FATHER

11. Industry or business _____

12. Name Eddie Mills

13. Birthplace D. K. Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Sister Madden Thompson

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

16. (a) Informant State Hosp.

(b) Address _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

17. (a) Burial (b) Date thereof 2/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Alvin F. ...

(b) Address 215 So. Jefferson St. St. Louis

19. (a) 2-17-1947 (b) John M. ...
(Date received local 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? Cemetery
(Specify type of place) (e) Means of injury 0

Signature P. S. Tate (M. D. or other) _____

Address State Hosp. #1 - Fulton Date signed 2-17-47

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 91
District File Number
Date Filed FEB 25 1997

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 *S J Watson*
Licensed Embalmer No. *2698*
P. O. Address *2769 Chouteau*

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.