

V. S. No. 2  
16M-12-45  
Rev. 5-17-39  
1 X47070

FILED JUL 25 1947

Registration District No. 3-17

Primary Registration District No. 6076

1. PLACE OF DEATH:

(c) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 122 days  
(Specify whether years, months or days)

In this community 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

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

(d) Street No. 2411 Dickson  
(If rural, give location)

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

3. (a) PRINT MILLS, FANNIE BELL  
FULL NAME

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife Frank Mills

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased 9 25 1918  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>28</u>	<u>9</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Mitchell Cogger

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

14. Maiden name Mattie Dismute

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

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Removal (b) Date thereof 7-19-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Birmingham Ala

18. (a) Signature of funeral director J. D. Richardson

(b) Address 2625 S. Main St. St. Louis

19. (a) 7-17-47 (b) Carl A. J. [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14  
year 1947 hour 9 minute 15 A. M.

21. I hereby certify that I attended the deceased from 3-14-47 19... to 7-14-47 19...  
that I last saw h. er alive on 7-14-47 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 8 mo. (??)

Due to 13 6

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature E. G. [Signature] (M. D. or other) \_\_\_\_\_

Address Robert Koch Hospital Date signed 7-14-47

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

1 copy 4/24/47

JUL 25 1947

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 A. P. Richardson  
Licensed Embalmer No. 2928  
P. O. Address 2625 Glasgow

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.