No. 2
-1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36029

FILED OCT 24 1947

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 9571

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: City Infirmary Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7-24-47 To (Specify whether
In this community 10-9-47 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. 5800 Arsenal Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Grace McMillan
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased September (Month) 17 (Day) 1873 (Year)

8. AGE: Years 74 Months 0 Days 22 If less than one day hr. min.

9. Birthplace Texas (City, town, or county) (State or foreign country)
10. Usual occupation ?
11. Industry or business

MOTHER FATHER
12. Name Charles McMillan
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Millie ?
15. Birthplace Unknown. (City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary
(b) Address 5600 Arsenal St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthews Cemetery
18. (a) Signature of funeral director Robert J. Ambruster Inc
(b) Address 6633 Clayton Rd
19. (a) OCT 10 1947 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9, year 1947 hour 2 minute 05 P.M.

21. I hereby certify that I attended the deceased from July 24, 1947, 19, to October 9, 1947, that I last saw her alive on October 9, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of the Larynx	6 mo
Due to	
Due to: Anemia secondary to Carcinoma	
Other conditions: Emaciated (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autops: not obtained

PHYSICIAN
Underline the cause of 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? Means of injury

23. Signature C. O. Shoney (M.D. or other)
Address 5600 Arsenal Date signed 10-9-47

Jefferson City Printing Co. (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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St Louis, Mo.

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.