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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 3 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36076

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9621

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: 2818 Lyon St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or Institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ooo
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 24 2818 Lyon St. 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lannie Mills

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 Widow 2

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

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

7. Birth date of deceased October (Month) 4 (Day) 1853 (Year)

8. AGE: Years 94 Months 0 Days 12 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant Wm. Harp
(b) Address 2818 Lyon St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-16-47 (Month) (Day) (Year)
(c) Place: burial or cremation McCrory, Arkansas

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) (Date) OCT 16 1947 (b) J. F. Breden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16 year 1947 hour 5 minute 05 A. M.

21. I hereby certify that I attended the deceased from ~~Oct 7~~ Sept 28 1947, to Oct 16 1947, that I last saw her alive on October 7 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Senility General debility Bronchitis Chronic. — Duration 3 months
Due to
Due to
Other conditions arteriosclerosis
(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) 9
While at work? (e) Means of injury

Signature Leroy E. Ellison MD (M. D. or other) MD
Address 3610 S. Broadway Date signed 10-16-47

(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. G W Wilkinson

Licensed Embalmer No. 3575

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.