

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **318**

Primary Registration District No. **1003**

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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location) 4 months
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 10 years
years, months or days

3. (a) PRINT FULL NAME Helen Mills

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col. 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 46 years
7. Birth date of deceased November 15 1901
(Month) (Day) (Year)

8. AGE: Years 46 Months 3 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Vance
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Pauline ?
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Frank Mills
(b) Address 4134 e Delmar Blvd.
17. (a) Burial (b) Date thereof 3-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St.
19. (a) MAR 10 1948 (Data received local registrar) J. F. Bredack (Registrar's signature)

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. 4134 e Delmar
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 6
year 1948 hour 1 minute 25 a. M.

21. I hereby certify that I attended the deceased from 12-11, 1948, to 3-6, 1948
that I last saw h. er alive on Mar. 6, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Cervix Uteri with Metastasis to Urethra and Bladder Duration Undet.

Due to _____
Due to _____

Other conditions Post-op. Bilateral Uretera-
(Include pregnancy within 3 months of death)
sigmoidostomy; Pyelonephritis with

Microscopic suppurative Hepatitis PHYSICIAN _____
Of operations _____
Of autopsy None
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 _____
23. Signature Merle M. Herrig (M. D. or other) _____
Address 2601 N Whittier Date signed 3/8/48

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

MOTHER FATHER

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 Fulton E Culkin

Licensed Embalmer No. 4198

P. O. Address St. Louis 13 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 318Primary Registration District No. 1003Registrar's No. 2402

1. PLACE OF DEATH:

- (a) County St Louis
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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)3. (a) PRINT
FULL NAME Helen Mills

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex
- F
5. Color of race
- B
6. (a) Single, widowed, married, divorced
- m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... year

7. Birth date of deceased
- Mar. 15 1895
-
- (Month) (Day) (Year)

8. AGE: Years
- 46
- Months
- 3
- Days
- 15
- (If less than one day) min.

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

10. Usual occupation

11. Industry or business

12. Name.....
 13. Birthplace (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....
 (b) Address.....
 17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

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

(b) Address.....

19. (a)
- MAR 29 1948
- (b)
- J. F. Bredecke
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
 (c) City or town..... (If outside city or town limits, write "RURAL")
 (d) Street No..... (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
 that I last saw him..... alive on..... 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

Due to.....

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 sta-
tistically.

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.....

Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

S-10487

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1.16