

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35139  
8443

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN St. Louis		a. STATE Missouri	
c. LENGTH OF STAY (In this place)		b. COUNTY Cape Girardeau	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2025 Maury		c. CITY (If outside corporate limits, write RURAL and give township) Cape Girardeau 0164	
		d. STREET ADDRESS (If rural, give location) 231 S. Frederick 1	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Henry	b. (Middle) S.	c. (Last) Mills	(Month) Oct.	(Day) 5,	(Year) 1950

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 19, 1884	9. AGE (In years last birthday) 66	# UNDER 1 YEAR Months	# UNDER 1 HR. Hours	# UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Miller	11. BIRTHPLACE (State or foreign country) Jackson, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Alexander Mills	13b. MOTHER'S MAIDEN NAME Sarah E. Foster	14. NAME OF HUSBAND OR WIFE Margaret
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 490-05-7279a	17. INFORMANT'S SIGNATURE OR NAME Mrs. Frank Garden, 7417 Warner	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 weeks  5 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
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22. I hereby certify that I attended the deceased from Oct 4, 1950, to Oct 5, 1950, that I last saw the deceased alive on Oct 4, 1950, and that death occurred at 12 Noon, from the causes and on the date stated above.

23a. SIGNATURE Martin W. Davis M.D.	(Degree or title)	23b. ADDRESS 539 N Grand Ave	23c. DATE SIGNED 10/6/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-9-50	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope	24d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd.
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DATE REC'D BY LOCAL REG. OCT 6 1950	REGISTRAR'S SIGNATURE J. B. Jasper	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....

working under my personal supervision.

Student Embalmer No.....

Signed

*Robert M. Murray*

Signed.....  
Student Embalmer

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.