

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7762**

No. 300
10-48

FILED MAR 11 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1774**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 22 205 S Leffingwell	

3. NAME OF DECEASED (Type or Print)	a. (First) Angelo	b. (Middle) -	c. (Last) McMillan	4. DATE OF DEATH (Month) (Day) (Year) Feb. 12 1953
-------------------------------------	--------------------------	----------------------	---------------------------	---

5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH 6-15-1914	9. AGE (In years last birthday) 38	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
--------------------	---------------------------------	---	-----------------------------------	---	-----------------------	---------------------	----------------------	---------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ABERDEEN MISS	12. CITIZEN OF WHAT COUNTRY?
--	-----------------------------------	---	------------------------------

13a. FATHER'S NAME HENDERSON McMillian	13b. MOTHER'S MAIDEN NAME MAIE WALKER	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Henderson McMillian Lawton	17. ADDRESS 2921
---	-------------------------	---	-------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Hypertension	DUE TO (b) Undetermined		Undet.
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None known		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 444X

22. I hereby certify that I attended the deceased from **2-4**, 19**53** to **2-12-**, 19**53**, that I last saw the deceased alive on **2-12**, 1953, and that death occurred at **6:47p** m., from the causes and on the date stated above.

23a. SIGNATURE Edward B Williams (Degree or title)	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 2-13-53
---	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 2-16-53	24c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. FEB 16 1953	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON	ADDRESS 2707 STODDARD ST.
---	--	---	----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 26 1930

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.....

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed

Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4534 Aldene

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.