

FILED OCT 9 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33736

8471

|   |                        |  |   |   |   |  |   |  |  |
|---|------------------------|--|---|---|---|--|---|--|--|
| BIRTH NO. _____   |                        | REG. DIST. NO. 318   |   | PRIMARY REG. DIST. NO. 1003   |   | Registrar's No. _____  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |                        |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri   |   |  |   | b. COUNTY St. Louis                      |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  |                        |  | c. LENGTH OF STAY (In this place) 36 hrs. | c. CITY (If outside corporate limits, write RURAL and give township) Maryland Heights   |   |  | d. STREET ADDRESS (If rural, give location) Dodridge Ave - Robertson, Mo. R#1-368 |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital  |                        |  |   | d. STREET ADDRESS (If rural, give location) Dodridge Ave - Robertson, Mo. R#1-368   |   |  |   | Box                                      |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Naomi   |                        |  | b. (Middle) Kathleen                      |   | c. (Last) Mills   |  | 4. DATE OF DEATH (Month) (Day) (Year) Aug. 29, 1953                               |  |  |
| 5. SEX Female   | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married                                   | 8. DATE OF BIRTH Dec. 22, 1913            |   | 9. AGE (In years last birthday) 9                                 | IF UNDER 1 YEAR Months   | IF UNDER 24 HRS. Days   | IF UNDER 24 HRS. Hours                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School age  |                        |  | 10b. KIND OF BUSINESS OR INDUSTRY at home |   | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |
| 13a. FATHER'S NAME Clarence Mills   |                        |  | 13b. MOTHER'S MAIDEN NAME Frieda A. Brown |   | 14. NAME OF HUSBAND OR WIFE None                                  |  |   |  |  |
| 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. None              | 17. INFORMANT'S SIGNATURE OR NAME Clarence Mills  |   |  |   | ADDRESS Robertson, Mo. R#1 Box 368       |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |                        |  |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute bacterial meningitis.   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH 1 week. |  |
|   |                        |  |   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |   |  |   |  |  |
|   |                        |  |   | II. OTHER SIGNIFICANT CONDITIONS*<br>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 checked="" type="checkbox"/> NO <input 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) _____  |   | 21d. (COUNTY) _____  |   | 21e. (STATE) _____                       |  |
| 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? 0800   |   |  |   |  |  |
| 22. I hereby certify that I attended the deceased from Aug 27, 1953 to Aug 29, 1953, that I last saw the deceased alive on Aug 29, 1953 and that death occurred at 9:30 p.m., from the causes and on the date stated above.     |                        |  |   |   |   |  |   |  |  |
| 23a. SIGNATURE (Degree or title) Dr. L. J. Lippert, MD  |                        |  |   | 23b. ADDRESS 3209 S. Lead   |   |  | 23c. DATE SIGNED 8-31-53  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal   |                        | 24b. DATE 9-1-1953   |   | 24c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery   |   | 24d. LOCATION (City, town, or county) Pattonville, Mo.                           |   | (State) _____                            |  |
| DATE REC'D BY LOCAL REG. AUG 31 1953  |                        | REGISTRAR'S SIGNATURE J. Carl Smith MD   |   | FUNERAL DIRECTOR'S SIGNATURE Blumhans Bros. Inc. 2504 Woodson Rd - Overland - Mo.   |   | ADDRESS _____  |   |  |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3474

P. O. Address Cambridge

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

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