

FILED MAR 25 1941

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 1448

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Days  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Caleb Mills

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Sarah Alice 6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased Jan 23  
(Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days 19 If less than one day hr. min.

9. Birthplace Cleaton, Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Samuel Mills

13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann

15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Delia Hudson

(b) Address 4015 Olive St

17. (a) Removal (b) Date thereof 2/14/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farmington, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) FEB 13 1941 (b) J. H. Srebrak  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 1719  
(If outside city or town limits, write "RURAL")  
4015 Olive St  
(d) Street No. 9  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? ..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12,  
year 1941 hour 2:30 minute ..... P. M.

21. I hereby certify that I attended the deceased from February 11, 1941 to February 12, 1941,  
that I last saw him alive on February 12, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Filmsis of Myocardium

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) 93

Major findings: Of operations 93

Of autopsy refused

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 A. B. S. M. D. (M. D. or other)  
Address 1515 Lafayette Avenue Date signed 2/13/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

20  
17  
19

**STATEMENT BY LICENSED EMBALMER**

4214

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.....

*R. W. Wilkinson*

Licensed Embalmer No. ....

*35-75*

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.**

Registration District No. 791

Primary Registration District No. 1003

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 Caleb Mills

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 23 1855  
(Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days 19 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 714-41 (b) JT Predeck  
(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 Feb day 12  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 JT Predeck (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

