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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22690

State File No. _____

Registration District No. 187

Primary Registration District No. 900

Registrar's No. 1178

1. PLACE OF DEATH:

(a) County St. Louis
(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:
Mt. St. Rose Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME CREECH, MILDRED

3. (b) If veteran, name war _____ 3. (c) Social Security No. 356-10-9549

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased UG 8 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 9 25 hr. _____ min.

9. Birthplace Elkville 1 Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Cook

11. Industry or business Restaurant

MOTHER FATHER { 12. Name Frank Creech
13. Birthplace Day City, Ill.
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Arvilla Williams
15. Birthplace Franklin Co. 1 Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Robin
(b) Address Dowell, Ill.

17. (a) Removal (b) Date thereof 6-4-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Francis, Ill.

18. (a) Signature of funeral director Albert H. Hoppel
(b) Address 4700 Washington St.

19. (a) JUN - 4 1941 (b) DR. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jackson 999
(c) City or town Dowell 11
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 3
year 4 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from
4/7 1941, to June 3 1941;
that I last saw her, alive on June 3 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Far advanced Pulmonary Tuberculosis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13/1
Of autopsy None

Duration
PHYSICIAN
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 W. H. Gerson (M. D. 0)
Address Mt. St. Rose Sanatorium Date signed 6-3-41

WRITE PLAINLY—USE 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 _____

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed _____

Gay W. Wilkerson

Licensed Embalmer No. 3575

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, above space should be left blank.