OCT 28 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

29413

1. PLACE OF DEATH

County Clay — Registration District No. 198 — File No.

Township ~~Fishing River~~ — Primary Registration District No. 3011 — Registered No. 86

City Excelsior Springs (No. ..... St. ..... Ward)

2. FULL NAME Chas W Milligan

(a) Residence. No. 427 North Kimball St., ... Ward. Cameron, Mo.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Jane Milligan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 1 - 1842

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	88	6	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER John Milligan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER Mary Groves

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

14. INFORMANT J. A. Milligan
(Address) Excelsior Springs, Mo.

15. FILED 9/15, 1930 Y. D. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Sept 14, 1930 that I last saw h~~ain~~alive on Sept 14, 1930, and that death occurred, on the date stated above, at 3:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoris
94A
162
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Aga
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at Place of Death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [signature], M. D.
9/15, 1930 (Address) Excelsior Springs Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Cameron, Mo.	9/16 1930

20. UNDERTAKER	ADDRESS
Herbert Hope	Excelsior Springs Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.