

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.

NOV 23 1927

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

Do not use this space.

33626

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township

Primary Registration District No. 85

City St. Joseph

(No. City Hospital)

File No. 1019

Registered No.

St.

Ward

2. FULL NAME Raymond W. Milbourn

(a) Residence, No. Route # 1 De Kalb Mo. St. De Kalb Ward. Route # 1 De Kalb Mo.  
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR

DIVORCED (write the word)

Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Oct. 17, 1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1  
day, ..... hrs.  
or ..... min.

3

11

18

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as splanner,  
sawyer, bookkeeper, etc.

At home

9. Industry or business in which  
work was done, as silk mill,  
saw mill, bank, etc.

10. Date deceased last worked at  
this occupation (month and  
year)

11. Total time (years)  
spent in this  
occupation

12. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)

Amazonia  
Missouri

MOTHER FATHER

13. NAME John Milbourn

14. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)

Amazonia  
Mo.

15. MAIDEN NAME Phoebe Meeker

16. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)

Amazonia  
Mo.

17. INFORMANT  
(ADDRESS)

John Milbourn  
Route # 1 De Kalb Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE

Bethel Cem.

DATE Oct. 7, 1927

19. UNDERTAKER  
(ADDRESS)

Fred B. Clark  
5025 King Hill Av.

20. FILED

10 6 31

John H. Bender

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Oct. 5, 1931

22. I HEREBY CERTIFY, That I attended deceased from

Oct 4th 31, to Oct 5th 31, 1931

I last saw him alive on Oct 5th 31, 1931. Death is said

to have occurred on the date stated above, at 10:15 pm.

The principal cause of death and related causes of importance were as follows:

Date of onset

Scarlet Fever. Dont know

Other contributory causes of importance:

Adenitis Nasillary glands

Name of operation opened abscess of gland Oct 5/31

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed)

A. E. Holley M.D.

(Address) 822 Edmond St. Joseph, Mo.

