

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.

1938 JAN 14 1938

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

43133
Do not use this space.

1. PLACE OF DEATH *Green*

(a) County *Greene* Registration District No. *316*
 (b) Township *Springfield* Primary Registration District No. *2001* Registered No. *1005*
 (c) City *Springfield* (d) Street No. *1235 N. Broadway* St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *WILLIAM J. MILLSTEAD*

(a) Residence, No. *1235 N. BROADWAY* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 17 - 1858*

7. AGE YEARS *80* MONTHS *5* DAYS *7* If LESS than 1 day, hrs. min. *Retired*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Elevator operator*

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

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) *Morgan Co. Ill*

FATHER 13. NAME *James Millstead*

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

MOTHER 15. MAIDEN NAME *Unknown*

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

17. INFORMANT (NAME) (ADDRESS) *Mrs. Rhoda Smith Springfield Mo.*

18. BURIAL, CREMATION OR REMOVAL PLACE *Green Lawn Dec 28 1938*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. H. Hines Co Springfield Mo.*

20. FILE NO. *Dec 28 1938* *Chas. A. George Mo. Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 24 1938*

22. I HEREBY CERTIFY, That I attended deceased from *12/14* 19*38*, to *12/24* 19*38*

I last saw him alive on *12/24* 19*38*. Death is said to have occurred on the date stated above, at *9:00 P.* m.

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

Pneumonia (Hypostatic)

Date of onset *12/14/38*

Other contributory causes of importance: *Arterio-Sclerosis*

Name of operation *None* Date of _____

What test confirmed diagnosis? *None* 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 _____, 19____

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) *Chas. A. George*, M. D.
 (Address) *Springfield Mo.*

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, Paul A. [unclear]
#1763 + Wm. D. Noblett #4005 copy Wm. Max Rhodes #4

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

Signed J. B. Klingner

Licensed Embalmer No. 3358

P. O. Address Springfield, Mo.

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.