

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

21285

Do not use this space.

REC'D JUL 10 1939

1. PLACE OF DEATH

(a) County JACKSON Registration District No. 399
 (b) Township RAW Primary Registration District No. 1002
 (c) City KANSAS CITY (d) Street No. R.C. GENERAL HOSPITAL Registered No. 2533
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred 20 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MISS SARAH ELIZABETH Mc MILLAN
 (a) Residence, No. 5824-FLMWOOD St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 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) SEPTEMBER? - 1879
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 59 9 unk
 8. Trade, profession, or particular kind of work done, as lawyer, bookkeeper, etc. SCHOOL TEACHER
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) 11-24
 11. Total time (years) spent in this occupation 26

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

FATHER 13. NAME THOMAS Mc MILLAN

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

MOTHER 15. MAIDEN NAME MARGUERITE M. CLEARY

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

17. INFORMANT MRS. MARGUERITE M. NORRIS
 (ADDRESS) 5824-FLMWOOD AVENUE

18. BURIAL, CREMATION, OR REMOVAL PLACE JACKSONVILLE, ILL. DATE JUNE-23 1939

19. FUNERAL DIRECTOR (NAME) DW. NEWCOMER'S SONS
 (ADDRESS) KANSAS CITY, MISSOURI

20. FILED 6/22 39 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JUNE-21 1939

22. I HEREBY CERTIFY That I attended deceased from _____, 19____

I last saw him/her Deceased alive on _____, 19____. Death is said to have occurred on the date stated above, at 7:58 P.M.
 The immediate cause of death and related causes of importance were as follows:

Acute cerebral poisoning
Acute hemorrhagic gastritis
 Date of onset _____

Other contributory causes of importance: 163

Name of operation _____ Date of _____
 What test confirmed diagnosis _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide. Date of injury 6-21-39
 Where did injury occur? K.C. Mo. (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Do not know
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) Dr. H. H. H. H. M. D.
 (Address) In Hosp. K.C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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 E M Colborn

Licensed Embalmer No. 3506

P. O. Address K C 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.