

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.

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

44937  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Warren Registration District No. 884  
 (b) Township Charette Primary Registration District No. 6126 Registered No. 15  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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. 4 ds. 13 How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Mrs. Mary Esther Mc. Millan

(a) Residence, No. \_\_\_\_\_ 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) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ( Mc Millan )  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 27, 1857  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
81 11 21

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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. Total time (years) spent in this occupation

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

FATHER 13. NAME P. W. Rogers

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

MOTHER 15. MAIDEN NAME Lucinda Wilkerson

15. BIRTHPLACE (CITY OR TOWN) ?  
 (STATE OR COUNTRY) Kentucky

17. INFORMANT Mary E. Mc Millan  
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Marthasville MO DATE Nov. 21 '39

19. FUNERAL DIRECTOR (NAME) Fred Whittum  
 (ADDRESS) Marthasville Mo

20. FILED Nov 20, 1939 J. J. Jones  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 18 1939

22. I HEREBY CERTIFY That I attended deceased from Oct 15, 1939, to Nov 18, 1939  
 I last saw her alive on Nov 4, 1939. Death is said to have occurred on the date stated above, at 11 P. m.  
 The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage  
 Other contributory causes of importance: arterio sclerosis  
Ch. myo carditis  
 Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? clinical Was there an autopsy? \_\_\_\_\_  
 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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Heber H. Schwed, M. D.  
 (Address) Marthasville, Mo

Date of onset  
Oct  
1939  
1939

**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

*Fred W. Lightenberg*

Licensed Embalmer No. *13215*

P. O. Address *Marthasville 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.**