

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FILED MAR 11 1940
399

State File No. 5272

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 497

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: K.C. Gen. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days /
(Specify whether
 In this community 40 Years
years, months or days)

3. (a) PRINT FRANK MILLIGAN
 FULL NAME
 3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Martha L. Milligan 6. (c) Age of husband or wife if alive 75 years
 7. Birth date of deceased Feb. 19, 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>11</u>	<u>12</u>	hr. _____ min.

9. Birthplace Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Wm. A. Milligan
 { 13. Birthplace Indiana
(City, town, or county) (State or foreign country)
 { 14. Maiden name Fannie Cason
 { 15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]
 (b) Address 3010 E. 60th K. C. Mo.

17. (a) Burial (b) Date thereof 2-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Freeman Mortuary
 (b) Address Kansas City, Mo. 361

19. (a) Feb. 2, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3010 E. 6th St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 1st
 year 1940 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1-24-40, 19____, to 2-1-40, 19____;
 that I last saw h. im alive on 2-1-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death CARDIAC DECOMPENSATION
 Due to 9502
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy None

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature: [Signature] (M.D. or other) _____
 Supt. K.C. Gen. Hospital, K.C. Mo. I.B.O.
 Address _____ Date signed _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

Clarence W. Childs

Licensed Embalmer No. *3473*

P. O. Address *Dr. Childs*

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.