

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

00455-17-39
Rev. 5-17-39
I X1951

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 5696

Registrar's No. 921

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:
General Hospital #2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2-17-40-2-25-40
 (Specify whether
 In this community 12 years
 years, months or days)

3. (a) PRINT FULL NAME Alice Millner

8. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Nathan Millner 6. (c) Age of husband or wife if alive 37 years
 7. Birth date of deceased 7 16 1909
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 7 9 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
 12. Name Clarence Hurtt
 13. Birthplace Mo. 6
 (City, town, or county) (State or foreign country)
 14. Maiden name Marie Woods
 15. Birthplace Mo. 0
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
 (b) Address General Hospital #2
 17. (a) Burial (b) Date thereof 2/28/40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Woodsland
 18. (a) Signature of funeral director Wattkins Bros
 (b) Address 1729 Levee
Feb. 28, 1940 (c) W. M. Crowe
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1101 Woodland Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 25
 year 40 hour 5 minute 20 A. M.
 21. I hereby certify that I attended the deceased from
2-17-, 1940 to 2-25-, 1940
 and that death occurred on the date and hour stated above.
 that I last saw her alive on 2-25-, 1940

Immediate cause of death Intestinal Obstruction

Due to Lympho Sarcoma

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Above Mentioned.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where and 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 J. C. Turner (M. D. or other) _____
 Address General Hospital #2 Date signed 2-26

Duraton

PHYSICIAN

Underline the cause to which death should be charged statistically

53-

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 Quac Jerome Manlove

Licensed Embalmer No. 3994

P. O. Address 1120 E. 23rd St.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 56967
Registrar's No. 921-

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town R.C.
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. (Specify whether
 In this community. years, months or days)

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

3. (a) PRINT FULL NAME Alice Millner
 3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced
 6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive year
 7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 h. min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name.

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

16. (a) Informant.

(b) Address.

17. (a) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address 1/28/40 M. M. Brown

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH. Month Feb. day 25 year 40 hour minute M.
 21. I hereby certify that I attended the deceased from 19..... to 19.....
 that I last saw him alive on 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Ob.
Lympho Sarcoma (Primary)
T. M. O.

Other conditions. (Include pregnancy within 3 months of death) 53

Major findings: Of operations.

Of autopsy.

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 P. C. Insner (M. D. or other)

Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER FATHER

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

S-5696