DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7208 3

Registration District No. 492

Primary Registration District No. 5652A

Registrar's No.

1. PLACE OF DEATH:

(a) County: Lincoln

(b) City or town: Rural – Monroe Twship (Home)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 8 miles west of Winfield, Mo. 2
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community: 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lincoln

(c) City or town: Monroe Township
(If outside city or town limits, write "RURAL")

(d) Street No.: 8 miles west of Winfield, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: John David Milburn 4th

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Prudie Kessinger

6. (c) Age of husband or wife if alive: 42 years

7. Birth date of deceased: Aug. (Month) 29 (Day) 1881 (Year)

8. AGE: Years 58 | Months 6 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace: Ohio County (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation: farming

11. Industry or business: ____

FATHER
12. Name: John Milburn
13. Birthplace: ____ (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Malvina Taylor
15. Birthplace: ____ (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant's own signature: Mrs John Milburn
(b) Address: Moscow Mills – R.F.D.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3 10 '40 (Month) (Day) (Year)
(c) Place: burial or cremation: New Galilee Cem.

18. (a) Signature of funeral director: O Garlan Ricks
(b) Address: Winfield Mo.

19. (a) 3/9/40 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th year 1940 hour 3 minute 10 A.M.

21. I hereby certify that I attended the deceased from Feb 1 – 1940, 19__, to March 8, 1940, that I last saw him alive on March 6, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis	15 years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically

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? ____ (Specify type of place)
(e) Means of injury ____
While at work? ____

23. Signature: [signature] (M. D. or other)
Address: Troy, Mo Date signed 3/9/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE 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.

80M-5-17-39
Rev. 5-17-39
I X19511

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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 O'Gardner Ricks

Licensed Embalmer No. 4012

P. O. Address Winfield, 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.

S. No. 2B
M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7208

Registration District No. 492 Primary Registration District No. 56529 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Monroe

(If outside city or town limits, write "RURAL" and name of township)

(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 years, months or days)

In this community

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 John David Milburn

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 8 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 8 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis

Due to Pulmonary

Due to

Other conditions (Include pregnancy within 3 months of death) nil

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. C. Creech (M. D. or other)

Address Troy Mo. Date signed

S-7208