

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

12748
 Do not use this space.

1. PLACE OF DEATH

(a) County Warren Registration District No. 681
 (b) Township Bridgeport Primary Registration District No. 6172 Registered No. 5
 (c) City _____ (d) Street No. 2 _____ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

457 Anna Elizabeth Millam
 (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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. P. Millam
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr. 21 1868
 7. AGE YEARS 71 MONTHS 10 DAYS 5 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Household
 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) Warren County
 (STATE OR COUNTRY) Mo.

FATHER 13. NAME W. T. Davidson
 14. BIRTHPLACE (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Sarah Hubbard
 16. BIRTHPLACE (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

17. INFORMANT Clay Millam
 (ADDRESS) Jonestown, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Wright Cem. DATE Mar. 7 1940

19. FUNERAL DIRECTOR (NAME) Earl Harding
 (ADDRESS) Jonestown, Mo.

20. FILED March 19 1940 A. W. Welling
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6 1940

22. I HEREBY CERTIFY, That I attended deceased from Mon. Feb. 12, 1940 to _____, 19____
 I last saw him alive on Mon. Feb. 12, 1940 Death is said to have occurred on the date stated above, at 9:45 am.
 The principal cause of death and related causes of importance were as follows:

malnutrition
infirmity of old
fall stairs approx

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) N. W. Alexander D. O.
 (Address) Jonestown, Mo.

K. 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.

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12748

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 881

Primary Registration District No. 6172

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Bridgeport Mo
(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.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna E. Millan

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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 71 Months 10 Days 5 If less than one day hr. 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) (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)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Mar day 4 year 1940 hour minute M.

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

Immediate cause of death malnutrition infirmities of age gall bladder infection (no operation) Duration

Due to.

Other conditions (Include pregnancy within 3 months of death) 127

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 W. W. Alexander M.D. (other)

Address Jonesburg Mo Date signed.

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-12748 - 1940