

MAY 15 1940

399

1002

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 1644

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: Research Hospital  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution 3 Days  
In this community 20 yrs. (Specify whether years, months or days)

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. 2503 W 47th Terrace  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13<sup>th</sup>  
year 1940 hour ten minute 24 A.M.  
21. I hereby certify that I attended the deceased from April 13  
1940, to April 13, 1940;  
that I last saw him alive on April 13, 1940;  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Hadsell A. Mills

8. (b) If veteran, Hadsell A. Mills 8. (c) Social Security name war. \_\_\_\_\_ No. X

4. Sex Male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife Maudie Mills 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 7 1870  
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 6 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation General laborer

11. Industry or business Retired St Ry, Employee

12. Name Henry Alden Mills

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

14. Maiden name Ann Johnson

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

16. (a) Informant's own signature Dorothy C. Mills

(b) Address 3843 Wabash - Kc Mo

17. (a) Burial (b) Date thereof 4-17-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Melody M. Gilla

(b) Address K.C. Mo

19. (a) Apr 17, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Bronchopneumonia Duration 3 days  
Due to Carcinoma of stomach 5 years  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 9 months of death) \_\_\_\_\_  
Major findings: Carcinoma of stomach  
Of operations \_\_\_\_\_  
Of autopsy metastatic carcinoma, widespread; Bronchopneumonia

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 C. J. Kent (M. D. or other) M. D.  
Address Research Hospital, K.C. Mo Date signed 4-17-40

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.

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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.**