

Form No. 1
-11-10-39
-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26023**

Registration District No. **688**

Primary Registration District No. **5916**

Registrar's No. **14**

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

1. PLACE OF DEATH:
 (a) County **Pike** *Perry Twp*
 (b) City or town **Frankford Missouri**
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location) **7**
 (d) Length of stay: In hospital or institution. (Specify whether) **Life**
 In this community **Life**
 years, months or days

3. (a) PRINT FULL NAME **Sarah Edna Milam** **450**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **Femal** **5. Color or race** **White**
6. (a) Single, widowed, married **Married**
6. (b) Name of husband or wife **Oliver Milam** **6. (c) Age of husband or wife if** **59**
alive **2** **1881**
7. Birth date of deceased **Aug**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	58	10	28	hr. min.

9. Birthplace **Pike County Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business
12. Name **David Harlinger**
13. Birthplace **Pennsylvania**
 (City, town, or county) (State or foreign country)
14. Maiden name **ARTEMESIA BUSBY**
15. Birthplace **FRANKFORD PIKE Co. Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Oliver Milam**
(b) Address **Frankford Missouri**

17. (a) **Burial** **(b) Date thereof** **July 2 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Fairview Frankford**

18. (a) Signature of funeral director **Fred L. ...**
(b) Address **Frankford Missouri**

19. (a) **July 20** **(b) Mattie Ursell**
 (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **30** 19**40**
 year **1940** hour **9** minute **10** P. M.

21. I hereby certify that I attended the deceased from **June 22**
 _____, 19**40**, to **June 30**, 19**40**
 that I last saw **her** alive on **June 25**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Beside**
Dementia
 Duration _____

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

23. Signature **Old ...** (M. D. or other) _____
Address **Frankford Mo** Date signed **7/6/40**

RECEIVED

District Health Officer No. 10

District File Number 8-40-1560

Date Filed AUG 8 1940

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 Lone Fields Megow

Licensed Embalmer No. 4093

P. O. Address Frankfort, 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.