

Registration District No. **85**

Primary Registration District No. **1001**

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

1. PLACE OF DEATH:

(a) County **Buchanan**

(b) City or town **St. Joseph**

(c) Name of hospital or institution: **St. Joseph's Hospital**
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution **few hours**
(Specify whether)

In this community **25 1/2**
years, months or days

3. (a) PRINT FULL NAME **INFANT McMillen**

3. (b) If veteran, name war **—**

3. (c) Social Security No. **none**

4. Sex **MALE**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **21 st** years

7. Birth date of deceased **Aug. 21 st 1940**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	0	4 hr. 30 min.

9. Birthplace **St. Joseph Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business

12. Name **W-L. McMillen**

13. Birthplace **St. Joseph Mo. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **PEARL LEWIS**

15. Birthplace **St. Joseph Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **IDA MAY FARIN**

(b) Address **5403 1/2 Lake St. Joseph, Mo.**

17. (a) **BURIAL** (b) Date thereof **Aug. 22 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MEMORIAL PARK**

18. (a) Signature of funeral director **FLEEMAN & SON INC**

(b) Address **St. Joseph Mo**

19. (a) **Aug. 22, 1940** (b) **H. J. Postlebusch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Buchanan**

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. **934 E. LAKE BLVD.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **22nd.**
year **1940** hour **3.** minute **17A.** M.

21. I hereby certify that I attended the deceased from **8-21-**
19**40**, to **8-22-** 19**40**;

that I last saw him alive on **8-21-** 19**40**;

and that death occurred on the date and hour stated above.

Immediate cause of death **atelectasis, fetal**

Due to **prematurity**

Due to **15 1/4**

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)

(While at work?) (e) Means of injury

23. Signature **McGriness** (M. D. or other) **MD**

Address **St Joseph Mo** Date signed **8/22/40**

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.....

Carl W. Hansen
3955
St. Joseph, 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, fact should be so stated above.