

Registration District No. 793

Primary Registration District No. 4474

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Blackburn
(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 9
(Specify whether

In this community Life
years, months or days)

3. (a) PRINT FULL NAME ADA MILKS 420

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

4. Sex Fe 5. Color or race Black 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Joe Miles 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan - 15 - 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 7 6 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER, FATHER { 12. Name Bud Berry 0

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

14. Maiden name Patty Miles

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

16. (a) Informant Joseph Miles

(b) Address Mt. Leonard, Mo

17. (a) Burial (b) Date thereof Aug - 26 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salt Pond Cemetery

18. (a) Signature of funeral director Harry Hershberger

(b) Address Marshall mo

19. (a) Aug 26-1940 (b) Mattie Weaster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Blackburn
(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 Aug day 21
year 1940 hour 4:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 27
19____, to Aug 21, 1940;

that I last saw her alive on Aug 21, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of breast and uterus 3 yrs
Duration

Due to _____

Due to _____

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

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? _____

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

23. Signature Paul Lowell M.D. (M. D. or other) _____

Address Blackburn Mo Date signed Aug 24-40

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

25

RECEIVED
District Health Officer No. 8,
District File Number 9-5-40
Date Filed

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 LeRoy Benz

Licensed Embalmer No. H.127

P. O. Address Marshall, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. **29758**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **793**

Primary Registration District No. **4474**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Saline**

(b) City or town **Blackburn**
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME **Ada Miles**

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

4. Sex **F** 5. Color or race **Black** 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 **41** Months **7** Days **6** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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.

20. DATE OF DEATH Month **Aug** day **21** 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 _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of breast and uterus**

Due to **Carcinoma of Breast (left)** 9-137

Due to **F Breast (left)**

Other conditions _____ (Include pregnancy within 3 months of death) **SD**

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

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

ROLLIEMIA 22659

