S. No. 2
—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. 34454

FILED NOV 12 1940

Registration District No. 1399

Primary Registration District No. 1002

Registrar's No. 3970

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3004 E. 32 St. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 14 Year's
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")

0 (d) Street No. 3004 E. 32nd St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Fred B. Milholland

3. (b) If veteran, name war None

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 ____ years

7. Birth date of deceased August (Month) 16 (Day) 1926 (Year)

8. AGE: Years 14 | Months 1 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation School Boy 0

11. Industry or business 0

FATHER
12. Name James Milholland
13. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Etta Burk
15. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country)

16. (a) Informant James Milholland
(b) Address 3004 E. 32nd St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. (Month) 16 (Day) 1940 (Year)
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Rose & Henderson
(b) Address 4139 E. 15th St.

19. (a) 10-15-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
year 1940 hour 6:10 minute A. M.

21. I hereby certify that I attended the deceased from Oct. 8 '40, 19__, to Oct. 14, 1940;
that I last saw him alive on Oct. 14, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: ACUTE CARDIAC DILATATION WITH FAILURE	2 HRS.
Due to: INFLUENZA	1 WK
Due to: (PROBABLY STREPTOCOCCUS)	
Other conditions (Include pregnancy within 3 months of death) 11B	

Major findings:
Of operations 0
Of autopsy 0

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 B. C. Linstead (M. D. or other) M.D.
Address 6944 Prospect. Date signed Oct. 15 '40

(Licensed Embalmer's Statement on Reverse Side) K.C.C.

Dr Quistgard
6944 Prospect
1-4 Tuesday

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 John B. Camp

Licensed Embalmer No. 25 55

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.