

399

1002

Registration District No.

Primary Registration District No.

Registrar's No. **4245**

RECEIVED DEC 21 1940

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K. C. General Hospital No. 1
(d) Length of stay: In hospital or institution 7 days
In this community 4 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 4205 E. 50th St. Terrace
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6th
year 1940 hour 5 minute 30 P. M.
21. I hereby certify that I attended the deceased from 10-30-40, 19____, to 11-6-40, 19____;

3. (a) PRINT FULL NAME ROSE MILLS

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife James M. Mills 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 20, 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Cole

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Clyde Spragins

(b) Address Seneca, Mo.

17. (a) Burial (b) Date thereof Nov. 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seneca, Mo.

18. (a) Signature of funeral director Rose & Henderson

(b) Address City

19. (a) 11-7-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

that I last saw her alive on 11-6-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA OF STOMACH

Due to 4/6

Due to _____

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

Major findings: Of operations _____

Of autopsy None

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 Med. Dir. K. C. Gen. Hospital (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *D. C. Henderson*

Licensed Embalmer No. 3657

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.