

FILED MAR 9 1942

Registration District No. 399

Primary Registration District No. 1002

State File No.

Registrar's No.

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 A. L. General Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 Hours  
(Specify whether)

In this community 46 yrs  
years, months or days

3. (a) PRINT FULL NAME Harold MILENS (Harry)

3. (b) If veteran, name war Worldwar No. I

3. (c) Social Security No.

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Edna

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Oct 30, 1895  
(Month) (Day) (Year)

8. AGE: Years 46 Months 3 Days 1 If less than one day  
hr. min.

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

10. Usual occupation Merchant

11. Industry or business Shoe & higger

12. Name Nyman Milens

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

14. Maiden name Sarah Simchi

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

16. (a) Informant M. G. Milens

(b) Address N. C. Mo

17. (a) Burial (b) Date thereof Feb 3, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Carmel

18. (a) Signature of funeral director J. P. Louis Funeral Home  
(City)

(b) Address —

19. (a) 2-3-42 (b) M. B. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 801 E Armour  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 1 year 42  
hour — minute — M.

21. I hereby certify that deceased died from 3:30 P.  
rupture of the brain on — 19—;  
that I was not alive on — 19—;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage

Rupture of the brain

Due to Auto trauma

Other conditions 170 C-1  
(Include pregnancy within 3 months of death)

Major findings: 28  
Of operations 28

Of autopsy Yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 123

(b) Date of occurrence 2-1-42

(c) Where did injury occur? 44 S. Jackson Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm or industrial place, in public place?  
While at work?

(e) Means of injury Drain of leg that ruptured  
(Specify type of place)

23. Signature M. B. Crowe (M. D. or other)

Address N. C. Mo Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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.....

*Bert Legan*

Licensed Embalmer No. *3979*

P. O. Address *H.C. 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.**