No. 2
-41
-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6200

FILED MAR 3 1942

Registration District No. 124

Primary Registration District No. 4070

Registrar's No.

1. PLACE OF DEATH:

(a) County Cape Girardeau

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

(c) Name of hospital or institution: Family Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community All life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

(c) City or town Jackson Mo. (If outside city or town limits, write "RURAL") 1 C

(d) Street No. 502 N. St. (If rural, give location) 0

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country 0

3. (a) PRINT FULL NAME Frank Edward Mills

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex Male D

5. Color or race W

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

6. (b) Name of husband or wife Anne Mills

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Feb (Month) 3rd (Day) 1881 (Year)

8. AGE: Years 60 Months 11 Days 3 If less than one day hr. min.

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

10. Usual occupation W.P.A. Labor

11. Industry or business

FATHER
12. Name Elie Mills 9
13. Birthplace Don't Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Foster
15. Birthplace Don't Know (City, town, or county) (State or foreign country) 9

16. (a) Informant Paul Wilson Mills

(b) Address Jackson Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-42 (Month) (Day) (Year)

(c) Place: burial or cremation Koehler Cemetery

18. (a) Signature of funeral director Seabaugh Fun Home

(b) Address Cape Girardeau Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1942 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from June 10, 1941 to Jan 10, 1942 that I last saw him alive on Jan 3, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death myocarditis	2 yrs
Due to Artero-Sclerosis	3 yrs
Due to Hypertention	3 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

93d

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 E R Schoen (M. D. or other) MD

Address Jackson Mo Date signed Jan 10

1116

(Licensed Embalmer's Statement on Reverse Side)

ED

District Health Officer No. 4

District File Number 242-188

Date Filed 2-11-42

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 W. H. Estes

Licensed Embalmer No. 3568

P. O. Address Cape Girardeau 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6200

Registration District No. 124 Primary Registration District No. 4070 Registrar's No.

1. PLACE OF DEATH

(a) County: Cape Girardeau

(b) City or town: Jackson
(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 years, months or days)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Frank E. Mills

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: Feb. 3 1882 (Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 3 (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 1/13 1942 (Date received local registrar) (b) J. H. Kerstner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19 year 1942 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.

	Duration
Immediate cause of death	
Due to	
Due to	
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 (M. D. or other)

Address Date signed

SUPPLEMENTARY