

FILED MAY 26 1942

Registration District No. 603

Primary Registration District No. 5799

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: West Sup
(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.....
years, months or days

3. (a) PRINT FULL NAME Basil 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, D divorced

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

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

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

8. AGE: Years 2 Months 1 Days 14

If less than one day..... hr. min.

9. Birthplace Marion Co. Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name William Mills

13. Birthplace Marion Co. Ala.
(City, town, or county) (State or foreign country)

14. Maiden name Myrtle Burks

15. Birthplace Marion Co. Ala.
(City, town, or county) (State or foreign country)

16. (a) Informant Mat Mills

(b) Address Canalou Mo.

17. (a) Burial (b) Date thereof 3/13/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Matthews Mo.

18. (a) Signature of funeral director Hunter Albright

(b) Address Sikeston Mo.

19. (a) Mar 12-42 (b) Wae Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

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

(d) Street No. 4 1/2 Miles Southeast of Canalou
(If rural, give location)

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

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 12 year 1942 hour 4 minute..... a.m.

21. I hereby certify that I attended the deceased from 3-11-42, 1942 to 3-12-42, 1942; that I last saw him alive on 3-11-42, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Duration 4 days

Due to.....

Due to.....

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

Major findings: 104

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 Howard M. Kendig (M. D. or other) ?

Address Sikeston Mo. Date signed 3-12-42

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

72
00

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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed Hunter Albritton

Licensed Embalmer No. 4210

P. O. Address Sikeston 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18577

Registration District No. 603

Primary Registration District No. 5799

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Rural
(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 Basil S. 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 s

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

7. Birth date of deceased Feb. 13, 1942
(Month) (Day) (Year)

8. AGE: Years 2 Months 1 Days 14 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) July 25, 1945 (b) Mae Brown
(Date received by 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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 12 Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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? _____

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

