No. 2
1-4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6491

Registration District No. FILED MAR 10 1943

Primary Registration District No. 4226

Registrar's No. 9

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

**1. PLACE OF DEATH:**

(a) County Holt

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

(c) Name of hospital or institution: 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 4 Mos 9 Days years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Holt 44

(c) City or town Corning (If outside city or town limits, write "RURAL") 0

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

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

If yes, name country 0

**3. (a) PRINT FULL NAME** CARLYNN FAY MILLS

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female

5. Color or race White

6. (a) Single, ~~widowed, married,~~ ~~divorced~~ Single 0

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased September (Month) 24 (Day) 1942 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 4 | 9 | hr. min. |

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

10. Usual occupation ✓

11. Industry or business ✓

FATHER
12. Name Floyd Mills 0
13. Birthplace West Plains (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Mary Spoon 0
15. Birthplace West Plains (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Mrs Floyd Mills

(b) Address Corning, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/43 (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Cemetery Craig Mo

18. (a) Signature of funeral director Schooler Funeral Home

(b) Address Fairfax, Mo.

19. (a) 2-4-43 (Date received local registrar) (b) Pauline Lawson (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Febr day 3rd year 1943 hour 6 minute 30 9 M.

21. I hereby certify that I attended the deceased from Febr 1st, 1943 to Febr 3, 1943 that I last saw her alive on Febr 3rd, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia — Duration 8 days

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 J. C. Atkinson (M. D. ~~or other~~)

Address Craig Mo Date signed 2/2/43

1181 (Licensed Embalmer's Statement on Reverse Side)

## 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 Marvin H. Schaeler

Licensed Embalmer No. 4162

P. O. Address Fairfax, Missouri

**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.**

U. S. No. 2B
OM—8-21-41
I X29288

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. 6491

Registration District No. ____ Primary Registration District No. 4224 Registrar's No. ____

**1. PLACE OF DEATH:**
(a) County: Holt
(b) City or town: Conway
(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: 4 mo 9 da

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Mo (b) County: Holt
(c) City or town: Conway
(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: Carlyman F. 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: Sept 24 — 1942 (Month) (Day) (Year)
8. AGE: Years 0 Months 4 Days ____ If less than one day ____ hr. ____ min.
9. Birthplace: Mo (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) ____ (Date received local registrar) (b) ____ (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July Day 3 year 1943 hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19____; that I last saw h. alive on ____, 19____; and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Bronchial Pneumonia | 8 da |
| Due to: | |
| Due to: No Complications | |
| 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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ____
While at work? ____ (Specify type of place) (c) Means of injury ____
23. Signature ____ (M. D. or coroner)
Address ____ Date signed ____

SUPPLEMENTARY