

FILED SEP 13 1943

State File No. \_\_\_\_\_  
Registrar's No. 228

Registration District No. \_\_\_\_\_

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Hicksville, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Lanahan Hosp. 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan <sup>105</sup>  
(c) City or town Green City <sup>0</sup>  
(If outside city or town limits, write "RURAL.")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no <sup>1</sup>

3. (a) PRINT FULL NAME Milton Andrews

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

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Etta Andrews 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased: 3 (Month) 27 (Day) 1874 (Year)

8. AGE: Years 69 Months 4 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Sullivan, Mo. 0 (City, town, or county) (State or foreign country)

10. Usual occupation Retired farmer

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Eden Edward Andrews  
13. Birthplace Indiana (City, town, or county) (State or foreign country)  
14. Maiden name Martha Ann Miller  
15. Birthplace Lancaster Co. Pa. 1 (City, town, or county) (State or foreign country)

16. (a) Informant Eden Andrews  
(b) Address Green Castle, Mo.

17. (a) Burial (b) Date thereof 8 22 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olivet Cem.  
18. (a) Signature of funeral director Henn E Dent-Son

(b) Address Green Castle, Mo  
19. (a) 8/26/43 (b) Mrs. J. Wayne  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19  
year 1943 hour 04 minute 55 A.M.

21. I hereby certify that I attended the deceased from August 14 1943 to Aug. 19 1943  
that I last saw h. alive on Aug 19 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Heart Disease (Chronic)  
Due to uremia  
Due to Pulmonary congestion  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations None  
Of autopsy \_\_\_\_\_  
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 J. M. [unclear] (M. D. or other) 280  
Address Hicksville, Mo. Date signed 8/19/43

RECEIVED

District Health Officer No. 10

District File Number 9-43-149 6

Date Filed SEP 10 1949

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirkville, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Laughlin Hosp.  
(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 Milton Andrews

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

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased: 3 (Month) 27 (Day) 1943 (Year)

8. AGE: Years 69 Months 4 Days 27 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or 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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Data received 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 July day 19 year 1943 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, immediate cause of death \_\_\_\_\_

Due to Uremia  
Chronic nephritis  
Due to Cardiac disease (chronic)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Wm Laughlin (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

27925