

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:  
3515 Wyandotte Street,  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution NO. (Specify whether  
In this community 74 years, (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Miss Josephine Millspaugh  
3. (b) If veteran, name war NO. 3. (c) Social Security No. NO.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Single  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife If alive X years  
7. Birth date of deceased July 4 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 4 10 hr. min.

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

10. Usual occupation at home,

11. Industry or business X

MOTHER FATHER { 12. Name A. W. Millspaugh  
13. Birthplace New York,  
(City, town, or county) (State or foreign country)  
14. Maiden name Fannie Seibert  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (c) Informant Mrs. Margaret Shine,

(b) Address 3915 Wyandotte, Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-43  
(Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 11-16-43 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson,  
(c) City or town Kansas City,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3515 Wyandotte Street,  
(If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 14th  
year 1943 hour 11:00 minute 0 A. M.

21. I hereby certify that I attended the deceased from Sept., 1943, to 11/14, 1943  
that I last saw h.s. alive on Sept., 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage

Due to Peptic Ulcer 11702<sup>2</sup>

Due to \_\_\_\_\_  
Other conditions Senility  
(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 H. E. Douglas (M. D. or other)  
Address 315 Alameda Rd. Date signed 11/15/43  
T. E. M.

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Dr. Douglass

*Admitted  
Feb 2 P.M.*

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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 *E. M. Plouffe*

Licensed Embalmer No. *1848*

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.**