

FILED JUN 13 1944

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

1. PLACE OF DEATH:

(a) County North
(b) City or town North MO.
(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 MARY ETTA MILLIGAN

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

4. Sex 7 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife W. J. Milligan 6. (c) Age of husband or wife if

7. Birth date of deceased Dec 10 1859
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 8 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name M. M. Spoonmore
13. Birthplace Missouri
14. Maiden name Marion Caber
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Danimar
(b) Address North MO

17. (a) (Burial, cremation, or removal) (b) Date thereof May 20-44
(Month) (Day) (Year)

(c) Place: burial or cremation Parson cemetery

18. (a) Signature of funeral director W. J. Andrews

(b) Address North MO

19. (a) May 20-44 (b) Arline Scadden
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County North
(c) City or town Grant City MO
(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 May day 11 year 1944 hour 8 minute 15 M.

21. I hereby certify that I attended the deceased from May 11 1944 to May 12 1944 that I last saw him alive on May 11 and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary

Due to

Age Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

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) no
(b) Date of occurrence March May
(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) Means of injury

23. Signature John Andrews (S. D. or other) Address North MO Date signed 5/18/44

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..... *Hayes Audubon*.....
Licensed Embalmer No. *2892*
P. O. Address *Worth 44*

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

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