

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED APR 17 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1387

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:
4037 CENTRAL STREET 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 30 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48
(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 4037 CENTRAL STREET
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. AGNES SOPHIA THOMPSON MILLS
3. (b) If veteran, name war No
3. (c) Social Security No. 486-09-8829

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month MARCH day 24TH
year 1945 hour 11 minute 45 A. M.
21. I hereby certify that I attended the deceased from 2/5/45
_____ 19____ to 3/24/45 19____
that I last saw her alive on 3/24/45
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MR. WALLACE S. MILLS
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased DECEMBER-13-1889
(Month) (Day) (Year)

Immediate cause of death Carcinoma of the ovary
Duration 1 yr.

8. AGE: Years 55 Months 3 Days 11
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
49 a

9. Birthplace CLAY CENTER KANSAS
(City, town, or county) (State or foreign country)

10. Usual occupation STENOGRAPHER

11. Industry or business WESTPORT LAUNDRY

12. Name MATT. THOMPSON

13. Birthplace NORWAY
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace NORWAY
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. MARIAN OSTLUND

(b) Address 4037 CENTRAL STREET

17. (a) BURIAL (b) Date thereof MAR. 26. 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. WASHINGTON CEM.

18. (a) Signature of funeral director W. H. Newcomers Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 3-26-45 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

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? _____

23. Signature John De Vane (Specify type of place) (c) Means of injury _____
Address 180 Regyle Bldg. L. C. Mo. (M. D. or other) Date signed 3/24/45

836 Orange St.
3:30 H.B.

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 Emile M. Calhoun
Licensed Embalmer No. 3506
P. O. Address Kemo

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.