S. No. 2
OM—2-43
v. 5-17-39
Ser I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30674

State File No.

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 105

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christa Nagan Hospital 0
(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 40 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Howell 46
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. South Hill
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Albert Millstead
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 M
6. (b) Name of husband or wife Mae Millstead
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased 12/8/1871 (Month) (Day) (Year)

8. AGE: Years 73 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Polo, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Live stock dealer
11. Industry or business
MOTHER FATHER
12. Name Jas. F. Millstead
13. Birthplace Tennessee (City, town, or county) (State or foreign country)
14. Maiden name Margaret Jennell
15. Birthplace Missouri 0 (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. G. Millstead
(b) Address West Plains, Mo.
17. (a) B (Burial, cremation, or removal) (b) Date thereof 9/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Lawn
18. (a) Signature of funeral director Roberts
(b) Address West Plains, Mo.
19. (a) OCT. 5, 1945 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18 year 1945 hour 1 minute 50 A.M.

21. I hereby certify that I attended the deceased from July 14, 1945 to Sept. 18, 1945 that I last saw him alive on Sept. 17, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Atherosclerosis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

Duration

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 0

23. Signature [illegible] (Title or address)
Address [illegible] Mo. Sept 24/45

1519 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 1045-517
Date Filed 10-13-45

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 D D Roberts

Licensed Embalmer No. 343

P. O. Address Mattawamkeag Me

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.