

FILED NOV 19 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 101

Primary Registration District No. 5393

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Douglas
 (b) City or town Ava Rural Benton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 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
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas
 (c) City or town Ava Rural
 (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.....

3. (a) PRINT FULL NAME Martha Milner

3. (b) If veteran, name war..... 3. (c) Social Security No. None

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

6. (b) Name of husband or wife J. F. Milner 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased June 22, 1883
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>4</u>	<u>5</u> hr. min.

9. Birthplace Jasper, Newton Co., Ark.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name A. C. Clifton
 13. Birthplace Scotland
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Garner
 15. Birthplace Scotland
 (City, town, or county) (State or foreign country)

16. (a) Informant William K. Knight
 (b) Address Summit Tex

17. (a) Burial (b) Date thereof 10-30-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ava

18. (a) Signature of funeral director Clinkingbeard Funeral Home

(b) Address Ava, Missouri

19. (a) Nov. 1 1945 (b) Vestal Bushman
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27
 year 1945 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw h..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death from fall off porch at her home, fractured skull, she was subject to heart attacks.

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months).....

Major findings: Of operations..... Of autopsy.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature C. V. Clinkingbeard (M. D. or other) 3 Coroner
 Address Ava, Missouri Date signed 10-29-45

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

RECEIVED

District Health Officer No. 6;

District File Number 1145-1103

Date Filed NOV 14 1945

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.....

Licensed Embalmer No. 3481

P. O. Address Orma Ind

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.

Registration District No. 101 Primary Registration District No. 5393

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(b) City or town Rural Benton sup
(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 Martha Milner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 22 1889
(Month) (Day) (Year)

8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Date 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 Oct Day 27 Year 1945 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, at _____, _____, _____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to Fall from porch at her home

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy 1945/10
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) Accident A 24 L
(b) Date of occurrence Oct. 27, 1945
(c) Where did injury occur? At her home, back porch
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Her home

While at work? _____ (Specify type of place)
(e) Means of injury Fractured skull
23. Signature C. W. Chickering (M. D. or other) Corone
Address Ava, Missouri Date signed 11-26-45

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

SUPPLEMENTARY

37055