

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41367

State File No. _____

FILED JAN 11 1946

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 136

1. PLACE OF DEATH:
 (a) County Howell
 (b) City or town West Plains
(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 John Newton Mills
 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 W
 6. (b) Name of husband or wife Virginia E. Mills | 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 3-28-1856
(Month) (Day) (Year)

8. AGE: Years 89 | Months 8 | Days 10 | If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired farmer

11. Industry or business _____

12. Name unk.

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

14. Maiden name unk.

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

16. (a) Informant Jetter Burroughs
 (b) Address West Plains, Mo.

17. (a) B (b) Date thereof 12-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Matthews, Mo.
 18. (a) Signature of funeral director Robertson
 (b) Address West Plains, Mo.
 19. (a) Jan 4, 1946 (b) Blady Harrison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Howell
 (c) City or town West Plains
(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 12 day 8
 year 1945 hour 6 minute 30 A.M.
 21. I hereby certify that I attended the deceased from July 15,
 1945 to Dec. 8, 1945;
 that I last saw him alive on Dec. 5, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Prostate and bladder. Sarcoma Carcinoma
 Duration ?

Due to _____
 Due to _____

Other conditions 5/18
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 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) _____
 (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 Asst. Thom. Burgh (M. D. or other) _____
 Address West Plains, Mo. Date signed 12/17/45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number

14644

Date Filed

1, 9, 46

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

A. A. Robertson

Licensed Embalmer No.

3432

P. O. Address

West Plains, 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.