

No. 2
5-43
5-17-39
X36671

FILED JUN 20 1947

Registration District No. **146**

Primary Registration District No. **5568**

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

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Independence Rural-Blue**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2340 Norwood Res.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community **7 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Independence Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2340 Norwood**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **RAY E. MILLBERN**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. **5706-05-9985**

4. Sex **male** **female**
 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Hannah N. Millbern**
 6. (c) Age of husband or wife if alive **43** years
 7. Birth date of deceased **June 28, 1898**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	48	11	13	hr. _____ min. _____

9. Birthplace **Ashland, Nebr.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Machinist**

11. Industry or business _____

12. Name **Wm. T. Millbern**

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

14. Maiden name **Allie Reynolds**

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

16. (a) Informant **Mrs. Hannah N. Millbern**

(b) Address **2340 Norwood, Independence, Mo.**

17. (a) **burial** (b) Date thereof **6/14/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Woodlawn Cemetery**

18. (a) Signature of funeral director **Geo. C. Carson Funeral**
 (b) Address **Independence, Mo. Home**

19. (a) _____ (b) **James Craig**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **11**
 year **1947** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Unknown**
 Duration _____

Due to **Pending 2006**
 Due to _____

Other conditions **Deputy Coroner**
(Include pregnancy within 3 months of death)

Major findings: **See Above**
 Of operations _____

Of autopsy **See Above**
 ADDITIONAL INFORMATION REQUESTED

22. If death was due to external causes, fill in the following: **REQUESTED**

(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) _____
 Means of injury **Auto**

23. Signature **W E Upsher** (M.D. or other) _____
 Address **2800 Main** _____

AUG 19 1947
AUG 28 1947
JUL 25 1947

JUN 1 1948

JUN 17 1948

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 *P. A. Leale*
Licensed Embalmer No. 4123
P. O. Address *Independence, 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.

No. 2
12-45
17-39
X47070

Registration District No. 146

Primary Registration District No. 5569

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural
(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)

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 _____

3. (a) PRINT FULL NAME Ray Milbern

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 _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

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

9. Birthplace _____ (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

acute carbon monoxide
intoxication

acute coronary
occlusion

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations Deputy coroner
Of autopsy See above

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) Suicide

(b) Date of occurrence 6-11-97

(c) Where did injury occur? Independence Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? in or about home

While at work? No (Specify type of place) (e) Means of injury Poisoning

23. Signature A.E. Elsker (M. D. or other) M.D.

Address 2800 Main Date 6/25/97

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

SUPPLEMENTAL

S-21325

STATEMENT BY LICENSED EMBALMER

APR 10 1947

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.....

P. O. Address.....

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.