

No. 2
-12-45
-17-39
17-47370

FILED DEC 1 1947

Registration District No. **1947**

Primary Registration District No. **4097**

Registrar's No. **178**

1. PLACE OF DEATH:
(a) County **Cass**
(b) City or town **Harrisonville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Memorial Hospital**
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution. (Specify whether years, months or days) **60 years.**

3. (a) PRINT FULL NAME **WILLIAM AARON MILLINGTON**
3. (b) If veteran. name war. **✓**
3. (c) Social Security No. **✓**

4. Sex **Male** 5. Color **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Grace Millington** 6. (c) Age of husband or wife if alive. **21** years (Month) **0** (Day) **1887** (Year)

8. AGE: Years **60** Months **0** Days **0** If less than one day hr. min.

9. Birthplace **Cass Co. Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Coal Dealer**

11. Industry or business

12. Name **W. A. Millington**

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

14. Maiden name **Clara Cordell**

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

16. (a) Informant **Mr. W. A. Millington**

(b) Address **Harrisonville, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Nov 23-1947** (Month) (Day) (Year)

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

18. (a) Signature of funeral director **KUNNERBURGER'S**

(b) Address **HARRISONVILLE, MO.**

19. (a) **Nov. 23-1947** (Date received local registrar) (b) **Laura J. Jones** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Cass** 19
(c) City or town **Harrisonville** 1
(If outside city or town limits, write "RURAL") **0**
(d) Street No. **404 Forest Ave** (If rural, give location)
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **21** year **1947** hour **9** minute **P.** M.
21. I hereby certify that I attended the deceased from **August 30**, 19**46** to **Nov. 21**, 19**47**
that I last saw him alive on **Nov. 21**, 19**47**; and that death occurred on the date and hour stated above.

Immediate cause of death **Asystole due to malignant hypertension** Duration **✓**
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: _____
Of operations: _____
Of autopsy: _____

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 **H. B. Newton** (M. D. or other) **0**
Address **Harrisonville, Mo.** Date signed **11-22-47**

ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUIRED if the cause to which death should be charged statistically.

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

FEB 24 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 Ernest Rememburg
Licensed Embalmer No. 3368
P. O. Address Harrisonville 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.

43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec
Registrar's No. 178

Registration District No. 59

Primary Registration District No. 4097

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Harrisonville
(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 Wm Aaron Millington
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 _____
7. Birth date of deceased Oct 21 (Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hr. _____ min.

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)
(Burial, cremation, or removal)

(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 21 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept 21 1947 to Oct 21 1947 and that death occurred on the date and hour stated above and that death was due to cardiac failure immediate cause of death

Due to Hypertension + Dilated aorta
Due to _____

Other conditions Senile Arteriosclerosis
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy 97

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 _____
23. Signature Harry B. Newsum (M. D. or other)
Address Harrisonville, Mo Date signed 12-12-47

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

SUPPLEMENTARY

37390

→ 100
100