

No. 2
8-43
7-39
37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 1 1948

Registration District No. 182

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16897

State File No. _____

Primary Registration District No. 4298

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Linneus
(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 Missouri (b) County Linn 58
(c) City or town Linneus
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country XXXX

3. (a) PRINT FULL NAME Florence Milburn

3. (b) If veteran, name war XXXX 3. (c) Social Security No. XXXX

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

6. (b) Name of husband or wife XXXX 6. (c) Age of husband or wife if alive XXX years

7. Birth date of deceased February 17, 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 2 21 hr. min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name George B. Milburn
13. Birthplace XXXXX Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Sophia Downey
15. Birthplace XXXXX Maryland
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Mrs Ralph Neal
(b) Address Linneus, Missouri
17. (a) Burial (b) Date thereof 5/11/1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Thorne Untd. Co.
(b) Address Linneus, Mo., (N.W. 2nd St)
19. (a) May 21-48 (b) Mrs Birdie Reiser
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8th.
year 1948 hour 9 minute P. 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 Chronic Myocarditis Duration 6 mos
Due to Chronic bronchitis (bronchiectasis) 20 yrs
Due to Arteriosclerosis, generalized
Other conditions Fracture left hip (intertrochanteric) 3 wks
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 7/8/6 ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED
Underline to which death certificate 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 5/8
(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) (c) Means of injury _____
23. Signature John R. Dyer (M. D. or other) M.D.
Address Brookfield, Mo. Date signed 5/10

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

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

W. R. Wright

W.R. Wright

Registered Apprentice No. **207**

working under my personal supervision.

Signed.....

Darr A. Taylor

Licensed Embalmer No. **3761**

P. O. Address **Linneus, Missouri**

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. 182

Primary Registration District No. 4298

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Linn
(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

Florence Melburn

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 S

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

7. Birth date of deceased Set 17 1904
(Month) (Day) (Year)

8. AGE: Years 86 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 _____

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 _____ (Burial, cremation, or removal) (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 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

Due to _____

Other conditions _____ (Includes 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) accident

(b) Date of occurrence April 18, 1948

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

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

While at work? no (Specify type of place) fell over chair at night (e) Means of injury

23. Signature John R. Dyer (M. D. or other) MD

Address Princeton Date signed to 12:45

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

SUPPLEMENTARY

S-16897