FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 21 1948

Registration District No. 146

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3026

State File No. 30046

Registrar's No. 278

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Walnut Park Church-Pearl & Alton 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1½ Hours (Specify whether
In this community 44 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 47
(c) City or town: Independence 4
(If outside city or town limits, write "RURAL")
(d) Street No.: 913 South Hocker 1 4
(If rural, give location)
(e) Citizen of foreign country? No. 0 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: CLARENCE NORMAN MILLARD
3. (b) If veteran, name war: ----------
3. (c) Social Security No. 496-09-8693

4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Henrietta Millard
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: November (Month) 28, (Day) 1874 (Year)

8. AGE:

Years	Months	Days	If less than one day
73	9	14	hr. min.

9. Birthplace: Madison, (City, town, or county) Wisconsin (State or foreign country) 1
10. Usual occupation: Unknown
11. Industry or business:
MOTHER FATHER
12. Name: No Data 9
13. Birthplace: No Data (City, town, or county) 1 (State or foreign country)
14. Maiden name: ? Freeman
15. Birthplace: No Data (City, town, or county) 9 (State or foreign country)
16. (a) Informant: Mrs. Helena Culp 1
(b) Address: Independence, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Mound Grove Cemetery
18. (a) Signature of funeral director: Roland R. Speaks
(b) Address: Independence, Missouri
19. (a) 9-14-48 (Date received local registrar) (b) [signature] (Registrar's signature) R.S.49

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 12th, year 1948 hour 10 minute 45 A M.
21. I hereby certify that I attended the deceased from Feb. 26th, 1937 to Sept. 12, 1948 that I last saw him alive on Sept. 11, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to:	Minutes
Due to: Arterial Hypertension	Years
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: X
Of autopsy: X
93A

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): X
(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: 0

CHAS. F. GRABSKE, M.D.
1st Nat'l. Bank Bldg.
INDEPENDENCE, MO.

23. Signature: Chas F. Grabske M. D. ~~or other~~
Address: Independence Mo. Date signed 9/13/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

JAN 20 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.....

Licensed Embalmer No. 3604

P. O. Address Independence, 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.

No. 2B
M—3-45
P 1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. D N

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 278

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Independence

(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 years, months or days)

In this community

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: Clarence H. Mullard

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: Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased: Mar. (Month) 28 (Day) 1875 (Year)

8. AGE: Years 73 Months 9 Days If less than one day hr. min.

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

10. Usual occupation: Retired

11. Industry or business: unknown

FATHER

12. Name

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

MOTHER

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1948 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
Due to	
Due to	
Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY 12

S-30046