

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

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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED MAR 4 1949
MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4267**
Registrar's No. **15**

Registration District No. **53** Primary Registration District No. **5790**

1. PLACE OF DEATH:
(a) County **Carroll**
(b) City or town **"RURAL"**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **67 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Carroll**
(c) City or town **"RURAL"**
(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 _____

3. (a) PRINT FULL NAME **CHARLES BRUCE MILLEMON**
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **70.**
4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Genevieve Millemont** 6. (c) Age of husband or wife if alive **78** years
7. Birth date of deceased **Aug. 25 1858**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **20th**
year **1949** hour **2** minute **00** A. M.
21. I hereby certify that I attended the deceased from **June**, 1948, to **Jan 20**, 1949
that I last saw him alive on **Jan 19**, 1949, and that death occurred on the date and hour stated above.
Immediate cause of death **Blanch's Trauma** Duration _____

8. AGE: Years Months Days If less than one day
90 4 25 hr. _____ min.

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

9. Birthplace **Indiana** (City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**
11. Industry or business _____
12. Name **George Millemont**
13. Birthplace **N.Y.** (City, town, or county) (State or foreign country)
14. Maiden name **Rebecca Cook**
15. Birthplace **Indiana** (City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: Of operations **49 1/2**
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
16. (a) Informant **Mrs. Shastis Millemont**
(b) Address **Carrollton Mo. P.O. # 2**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-2-49** (Month) (Day) (Year)
(c) Place: burial or cremation **Oak-Hill Cemetery**
18. (a) Signature of funeral director **Marshall Funeral Home**
(b) Address **Carrollton Mo.**
19. (a) **2/21/49** (Date received local registrar) (b) **Mrs. Herbert Abbott** (Registrar's signature)

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 **J. M. Edwards** (M. D. or other **M.D.**)
Address **Carrollton Mo.** Date signed **2-21-49**

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-3-49

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 2525

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton, 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.