

FILED AUG 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27497

Dr Chandler

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 238 PRIMARY REG. DIST. NO. 5821 Registrar's No. 96

1. PLACE OF DEATH a. COUNTY <b>New Madrid</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>R.F.D. # 3 Matthews, Mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>R.F.D. # 3 Matthews, Mo</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) <b>Margaret M Mills</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7 30 1949</b>		
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	
8. DATE OF BIRTH <b>9/27/48</b>		9. AGE (In years last birthday) <b>10 3</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Gruine Ala</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					

13a. FATHER'S NAME <b>Henry Mills</b>		13b. MOTHER'S MAIDEN NAME <b>Barbara Heyne</b>		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>X</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Barbara Mills Matthews M</b>		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Enterocolitis -</b>							
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>57/10</b>	

18a. DATE OF OPERATION		18b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>O.B. Chandler M.D.</b> (Degree or title)		23b. ADDRESS <b>New Madrid Mo</b>		23c. DATE SIGNED <b>7/31/49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>7/31/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Matthews Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Matthews, Mo</b>	
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DATE REC'D BY LOCAL REG. <b>8-2-49</b>		REGISTRAR'S SIGNATURE <b>Helene Louise Jones</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>James C. Whitton</b>		ADDRESS <b>Mo</b>	
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74-35122

RECEIVED AUG 12 1949  
District Health Office No. 2,  
District File Number 849-824  
Date Filed \_\_\_\_\_

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 \_\_\_\_\_

*Cavity emb*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed *John Allerton*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2941

P. O. Address *Superior Ave*

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.