

FILED OCT 8 1949

STANDARD CERTIFICATE OF DEATH

State File No. 29622

BIRTH NO. REG. DIST. NO. 66 PRIMARY REG. DIST. NO. 2250 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY Chariton, Clark Twp.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Chariton	
b. CITY OR TOWN Marceline, Rural		c. CITY OR TOWN Marceline, Rural	
c. LENGTH OF STAY (in this place) 26 yrs		d. STREET ADDRESS (If rural, give location) Rfd 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION none			

3. NAME OF DECEASED (Type or Print) James McMillan			4. DATE OF DEATH (Month) (Day) (Year) Sept. 2, 1949		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 4, 1876		9. AGE (In years last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Morgan Co., Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Robt. McMillan	13b. MOTHER'S MAIDEN NAME Elizabeth Connely	14. NAME OF HUSBAND OR WIFE Ora Tayler McMillan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mrs. James McMillan	ADDRESS Marceline, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis in R. Lung		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dysentery		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		002X

19a. DATE OF OPERATION	19b. 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug 15, 1949, to Sept 3, 1949, that I last saw the deceased alive on Sept 2, 1949, and that death occurred at 1:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE Sheila W. Smith (Degree or title)	23b. ADDRESS Marceline, Mo.	23c. DATE SIGNED 9-3-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 5, 1949	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	24d. LOCATION (City, town, or county) (State) Marceline, Mo.
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DATE REC'D BY LOCAL REG. Sept-5-49	REGISTRAR'S SIGNATURE Martha Clark	25. FUNERAL DIRECTOR'S SIGNATURE James McMillan	ADDRESS Marceline, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED OCT 4

District Health Officer No. 8,

District File Number.....

Date Filed 10-6-49

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.....

Student Embalmer No.

working under my personal supervision.

Signed Blanche McLaughlin

Signed.....
Student Embalmer

Licensed Embalmer No. 1909

P. O. Address Marshallia

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.