

FILED OCT 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33463

No. 300
10-48

BIRTH NO. _____ REG. DIST. NO. 108 PRIMARY REG. DIST. NO. 5423 499 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>DUNKLIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>DUNKLIN</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ARBYRD</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ARBYRD</u>	
c. LENGTH OF STAY (in this place) <u>60 YRS.</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>AT HOME</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>MADISON</u> c. (Last) <u>MILLSTEAD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 16 1949</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED; WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept 14, 1856</u>	9. AGE (In years last birthday) <u>92</u>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HICKMAN, Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME <u>Henry Millstead</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH SHOTT</u>	14. NAME OF HUSBAND OR WIFE <u>NANCY</u>
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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)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>H.F. MALLOY</u>	ADDRESS <u>Arbyrd, Mo</u>
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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) <u>CARDIO RENAL Condition</u>		II. OTHER SIGNIFICANT CONDITIONS <u>Senility</u>		44 2X
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b) _____		DUE TO (c) _____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	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 MAY 16, 1949, to MAY 16, 1949, that I last saw the deceased alive on MAY 15, 1949, and that death occurred at 2:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. W. English M.D.</u>	23b. ADDRESS <u>CARDWELL, MISSOURI</u>	23c. DATE SIGNED <u>10-8-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>10-12-49</u>	REGISTRAR'S SIGNATURE <u>Mrs J J Lanier</u>	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 17 19
District Health Office No.
District File Number 1049-11
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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.