

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32670**
Registrar's No. **1120**

BIRTH NO. **06676-51** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) St Joseph, Mo		c. CITY (If outside corporate limits, write RURAL and give township) St Joseph 0117	
c. LENGTH OF STAY (In this place) 1 day 35 hrs		d. STREET ADDRESS (If rural, give location) 2411 Tham St. Joseph Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Cherie b. (Middle) Lee c. (Last) Millbourn		4. DATE OF DEATH (Month) (Day) (Year) 10 26 51	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 10-25-51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS. Min. 1 35
11. BIRTHPLACE (State or foreign country) St Joseph, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Kenneth Wayne Millbourn	13b. MOTHER'S MAIDEN NAME Jean Jean Main	14. NAME OF HUSBAND OR WIFE Mrs. Ted Main
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME At St. Joseph

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity (6 MO)		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 774X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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
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22. I hereby certify that I attended the deceased from **26 Oct, 1951**, to **26 Oct, 1951**, that I last saw the deceased alive on **26 Oct, 1951**, and that death occurred at **1:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE Clement P. Schmitt	(Degree or title)	23b. ADDRESS St. Joseph Mo	23c. DATE SIGNED 26 Oct 51
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24a. BURIAL, CREMATION, REMOVAL (Specify) 11	24b. DATE Oct 27-51	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Joseph Mo
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DATE REC'D BY LOCAL REG. Nov. 7, 1951	REGISTRAR'S SIGNATURE Carl C. Castle	25. FUNERAL DIRECTOR'S SIGNATURE Stoney Funeral Home	ADDRESS St. Joseph
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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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed _____

John Roy Staine

Licensed Embalmer No. 2435

P. O. Address St Joseph

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.