

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**39420**

State File No. \_\_\_\_\_

**FILED DEC 1 1952**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 198 PRIMARY REG. DIST. NO. 4316 Registrar's No. 164

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Macon</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u> <u>0610</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. _____		d. STREET ADDRESS (If rural, give location) _____	

**3. NAME OF DECEASED** (Type or Print) a. (First) Julia b. (Middle) Ann c. (Last) Milliron

**4. DATE OF DEATH** (Month) (Day) (Year) Nov. 12, 1952

<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Widow</u>	<b>8. DATE OF BIRTH</b> <u>March 9, 1872</u>	<b>9. AGE</b> (In years last birthday) <u>80</u>	# UNDER 1 YEAR <u>8</u> Days	# UNDER 1 YEAR <u>3</u> Hours	# UNDER 1 MIN. Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>	<b>11. BIRTHPLACE</b> (State or foreign country). <u>Russell Twp. Macon County, U.S.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>
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<b>13a. FATHER'S NAME</b> <u>William Burris</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Katherine Trail</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>William Milliron</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO.</u>	<b>16. SOCIAL SECURITY NO.</b> <u>Mo.</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <u>Mrs. Delia Smith, New Cambria, Mo.</u>
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<b>18. CAUSE OF DEATH.</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, athermia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 yr</u>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cancer of the Colon</u>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
<b>II. OTHER SIGNIFICANT CONDITIONS:</b> Conditions contributing to the death but not related to the disease or condition causing death. _____			

<b>19a. DATE OF OPERATION</b> <u>_____</u>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>_____</u>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT, SUICIDE, HOMICIDE</b> (Specify): _____	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <u>_____</u>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <u>153X</u>
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**22. I hereby certify that I attended the deceased from July, 1952, to Nov. 12, 1952, that I last saw the deceased alive on Nov. 12, 1952, and that death occurred at 5:30 p.m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <u>C. West M.D.</u>	<b>23b. ADDRESS</b> <u>New Cambria Mo</u>	<b>23c. DATE SIGNED</b> <u>Nov 13/52</u>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>24b. DATE</b> <u>Nov. 14, 1952</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cambria Cemetery</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>New Cambria, Mo.</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>11-16-52</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Josephine King</u>	<b>397</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.F. Kelleland</u>	<b>ADDRESS</b> <u>New Cambria Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 11-24-52  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 11-52,196  
Date Filed 11-28-52

(24)

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. ....

Signed.....  
Student Embalmer

Signed *J. B. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield 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.