

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

8825

State File No.

1143

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	c. LENGTH OF STAY (in this place) <u>5 YEARS</u>	c. CITY OR TOWN <u>Kansas City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>		• STREET ADDRESS (If rural, give location) <u>1028 West 58 Street</u> <u>3828</u>	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) <u>Laura</u>	b. (Middle) <u>B.</u>	c. (Last) <u>Mills</u>	
		(Month) (Day) (Year) <u>March 10, 1954</u>	

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>APRIL-6-1870</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and State or Foreign Country) <u>Trenton, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN CURTIS</u>	13b. MOTHER'S MAIDEN NAME <u>SADRE ANN UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>W. C. MILLS</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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MR. CUSTER P. GALLAGHER</u>	ADDRESS <u>1028 W. 58 ST. KANSAS CITY, MO.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>5 days</u> <u>years (10)</u> <u>2 1/2 x</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Massive Gastric-Intestinal Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Intestinal Obstruction</u> DUE TO (c) <u>Bilat large Ovarian Cysts.</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility - Chronic Urogenital</u>			

19a. DATE OF OPERATION <u>3-6-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Bilateral Ovarian Cysts large - Intestinal Obstruction</u>	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 3-6, 1954, to 3-10, 1954, that I last saw the deceased alive on 3-10, 1954, and that death occurred at 8:40 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Walter Cummins</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>1612 Prof. Bldg.</u>	23c. DATE SIGNED <u>3-11-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>MAR. 12-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>3-13-54</u>	REGISTRAR'S SIGNATURE <u>Sheldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>QU NEWCOMERS INC</u>	ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO</u>
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(Licensed Embalmer's Statement on Reverse Side)

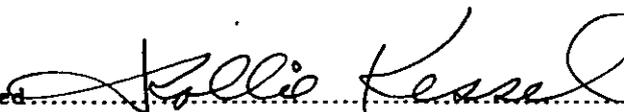
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 469.....

P. O. Address K. C. N.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.