

FILED MAR 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4235**

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 18

002
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1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Excelsior Springs</u>	c. LENGTH OF STAY (in this place) <u>7 years</u>	c. CITY OR TOWN <u>Excelsior Spgs</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>614 Owen</u>		e. STREET ADDRESS (If rural, give location) <u>614 Owen</u> <u>6002</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ARTHUR</u>		b. (Middle)		c. (Last) <u>MILLS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb</u> <u>1</u> <u>1955</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>July 10 1875</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 24 HRS. Days <u>20</u> Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Orrick Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Henry Mills</u>		13b. MOTHER'S MAIDEN NAME <u>Lucindy Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Bessie Mills</u>	
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>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Marsh Camden, Ex. Springs Mo.</u>	

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>Coronary arterial sclerosis</u>		<u>unk.</u>	
		ANTECEDENT CAUSES <u>Infarction.</u>			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>generalized arterial sclerosis</u>		<u>57 yrs.</u>	
		DUE TO (c) <u>including cerebral arterial sclerosis.</u>			
		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 <u>334X</u>		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) (Min.)		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 10-20, 1954, to 2-1, 1955, that I last saw the deceased alive on 1-10, 1955, and that death occurred at 6:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Doris M. Misgrace M.D.</u>		23b. ADDRESS <u>Excelsior Springs, Mo</u>		23c. DATE SIGNED <u>2-2-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/3/1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Riffe Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Near-Orrick Ray Co. Mo.</u>	

DATE REC'D BY LOCAL REG. <u>2/12/55</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Vergil Hope Ex. Springs Mo</u>	
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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, ~~only~~, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James A. Mot*.....

Licensed Embalmer No. 329.....

P. O. Address Excelsior S.....

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.