

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018384
STATE FILE NUMBER
2160

FILED MAY 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION W. A. Hospital		Length of stay in lb 48 yrs	d. STREET ADDRESS (If outside, give location) 909 E. 59th Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last WALTER A. MILLS			4. DATE OF DEATH Month Day Year 4th 25th 1958		
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-79		9. AGE (In years last birthday) 79 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	11. BIRTHPLACE (City and state or country) Lincoln, England		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Johnathon Mills		13b. MOTHER'S MAIDEN NAME Elizabeth Creasy		14. NAME OF HUSBAND OR WIFE Mabel Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW		16. SOCIAL SECURITY NO. 495-10-3528		17. INFORMANT Mrs. Rosa Campbell Address 909 E. 59th, K.C., Mo W. A. Hospital Records, K.C., Mo	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebrovascular thrombosis with hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. Attended the deceased from April 11, 1958 to April 25, 1958 and was present at his death Death occurred at 3:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE A. B. WILLIAMSON, M.D.				22b. ADDRESS W. A. Hospital, K.C., Mo	
				22c. DATE SIGNED 4-25-58	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Apr. 28, 1958		23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY		23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS, KANSAS CITY, Mo				25. DATE RECD. BY LOCAL REG. 4-28-58		26. REGISTRAR'S SIGNATURE Irene Marshall	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION



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 *Chester K Brown*

Licensed Embalmer No. *4931*
P. O. Address *K E 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.