

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022749
STATE FILE NUMBER

Dr. McCoy
FILED JUN 16 1958

Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 40

S. 300
1-57

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

1. PLACE OF DEATH a. COUNTY <u>Commiss</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Commiss</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Caruthersville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Caruthersville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b <u>None</u>	d. STREET ADDRESS (If outside, give location) <u>201 E 8th St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida May Milligan</u>			4. DATE OF DEATH Month Day Year <u>5-28-58</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-1885</u>
9. AGE (In Years) (If UNDER 1 YEAR, last birthday) (If UNDER 24 HRS., Months Days Hours Min.) <u>72 6 7</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Work</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Gibson Co Tenn</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Sam Milligan</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Dillard M Milligan</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. <input checked="" type="checkbox"/>	17. INFORMANT Address <u>Mrs Sada House Detroit Mich</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>260X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>years</u>
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>2-6-54</u> to <u>5-28-58</u> and last saw ^{her} _{him} alive on <u>5-28-58</u> Death occurred at <u>2 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Walter L. McCoy, M.D.</u>		22b. ADDRESS <u>Caruthersville Mo</u>	22c. DATE SIGNED <u>6/5/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5-30-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>First Lutheran</u>	23d. LOCATION (City, town, or county) (State) <u>Caruthersville Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Sherman Funeral Home Steubenville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 11, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Fessie B. Wilke</u>

6-168-58

JUN 13 1958

PEMISCOT COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARUTHERSVILLE, MO.

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 *Paul C. Dean*

Licensed Embalmer No. *3941*

P. O. Address *Caruthersville*

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.