

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017861

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 2072

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4123 Indep. Ave</b>		d. STREET ADDRESS (If outside, give location) <b>325 N. Heardesty</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Josephene</b> Last <b>Milks</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-9-1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Lawrence Kansas</b>	
13a. FATHER'S NAME <b>Alvah S. Baldwin</b>		14. NAME OF HUSBAND OR WIFE <b>Bert H. Milks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b>		<b>unknown</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)		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 <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. I attended the deceased from Death occurred at <b>4/21/59 1:55 P.M.</b>		to <b>4/22/59</b> and last saw her alive on <b>4/22/59</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Leo Vogan</b> (Degree or title) <b>D.O.</b>		22b. ADDRESS <b>4605 Independence Ave.</b>	
		22c. DATE SIGNED <b>4/24/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> DATE <b>4*25-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>	
		23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>	
24. FUNERAL DIRECTOR <b>Sheil Funeral Home K. C. Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>4.25-59</b>	
		26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Leo Vogan

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 *Richard E. Carroll* .....

Licensed Embalmer No. *4829* .....

P. O. Address *R. E. Ma* .....

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.