

STATE OF MISSOURI - DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035519

STATE FILE NUMBER

FILED VS. OCT 22 1959

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 93

ENDED

1. PLACE OF DEATH a. COUNTY CLAY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs		Length of stay in 1b 3 wks.		c. CITY OR TOWN LAWSON		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION SHARP Rest Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) RAY County		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First CLARENCE Middle HOWARD Last MILLIKEN				4. DATE OF DEATH Month Oct. Day 3 Year 1959									
5. SEX MALE		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-3-1885		9. AGE (last birthday) 74		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER-				10b. KIND OF BUSINESS OR INDUSTRY ✓		11. BIRTHPLACE (City and state or country) Kingman County Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME John E. Milliken				13b. MOTHER'S MAIDEN NAME MARY URQUHART				14. NAME OF HUSBAND OR WIFE Elsie G. Milliken					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address Elsie G. Milliken, Excelsior Springs, 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) Congestive Circulatory Failure										INTERVAL BETWEEN ONSET AND DEATH days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Palpable Reentry arrhythmia by Central monitor, accident													
DUE TO (c) Chronic Coronary Arteriosclerosis										year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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 a.m. Month, Day, Year 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. I attended the deceased from 1958 to Oct 3, 1959 and last saw him alive on Oct. 2, 1959 . Death occurred at 5:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE C. F. Lambert D.O.						22b. ADDRESS Box 606 Excelsior Springs, Mo.			22c. DATE SIGNED 10-3-59				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Oct. 5 1959		23c. NAME OF CEMETERY OR CREMATORY GREENLAWN				23d. LOCATION (City, town, or county) (State) PLATTSBURG MISSOURI					
24. FUNERAL DIRECTOR LYON FUNERAL HOME				ADDRESS Plattsburg, MO.				25. DATE RECD. BY LOCAL REG. 10/8/59		26. REGISTRAR'S SIGNATURE Caroline Ketchings			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Philip E. Cop

Licensed Embalmer, No. 1993

P. O. Address Haverhill, Mass.

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.