

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040239

FILED VS NOV 30 1959

149

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

5481

STATE FILE NUMBER

RECEIVED

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		Length of stay in 1b 15 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION 5437 E. 27th St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5437 E. 27th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Lucius Middle A. Last Mills			4. DATE OF DEATH Month Nov. Day 12, 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 4/20/85	9. AGE (last birthday) 74	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY self	11. BIRTHPLACE (City and state or country) Burr Oaks, Wis.	12. CITIZEN OF WHAT COUNTRY U. S. A/	
13a. FATHER'S NAME Asa Mills		13b. MOTHER'S MAIDEN NAME Ada Terrell		14. NAME OF HUSBAND OR WIFE Margaret Mills	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 332-12-3484	17. INFORMANT Address Margaret P. Mills 5437 E. 27th St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hr Years
DUE TO (b) Cerebral arteriosclerosis and hypertension		
DUE TO (c) _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial asthma; chronic bronchitis; pyelonephritis		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
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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 _____		

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
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21. I attended the deceased from **November 9, 1950** to **Nov. 12, 1959** and last saw **her** him alive on **September 28, 1959**
Death occurred at **6:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M.D.	22b. ADDRESS 4800 E 24th	22c. DATE SIGNED 11-12-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/14/1959	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Earp & Sons 4707 Truman Rd. K.C. Mo.	25. DATE RECD. BY LOCAL REG. 11-13-59	26. REGISTRAR'S SIGNATURE [Signature]
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Long**

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 William H. Eaga

Licensed Embalmer No. 4728

P. O. Address KC 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.