

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007157

FILED VS FEB 29 1960 385

Registration District No. _____ Primary Registration District No. 3039 Registrar's No. 99

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>LINN</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>LINN</u> c. CITY OR TOWN <u>MARCELINE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>112 E. BISBEE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWSON MILAM</u>			4. DATE OF DEATH Month Day Year <u>FEB 8 1960</u>				
5. SEX <u>MALE</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>8-5-1899</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours _____ Min. _____ IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARCELINE GREENH.</u>		11. BIRTHPLACE (City and state or country) <u>HUMBOLT NEB.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>CYRUS MILAM</u>		13b. MOTHER'S MAIDEN NAME <u>JENNY COATNEY</u>		14. NAME OF HUSBAND OR WIFE <u>ELLA MILAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>500-36-3840</u>		17. INFORMANT Address <u>ELLA MILAM MARCELINE MO.</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>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of the lung with metastases</u> DUE TO (c) <u>to the osseous structures</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dehydration gastric ulcer & repeated hemorrhage.</u>					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. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>1956</u> to <u>1960</u> and last saw him alive on <u>Feb 8, 1960</u> Death occurred at <u>2:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Marceline Milam</u>				22b. ADDRESS <u>Marceline Milam</u>		22c. DATE SIGNED <u>2-8-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>MARCELINE MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>MILLER-TILLOTSON MARCELINE MO.</u>			25. DATE RECD. BY LOCAL REG. <u>2-9-60</u>		26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>		

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B. J. Lindley
Licensed Embalmer No. 4822

P. O. Address Chillicothe

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.