

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED APR 30 1962 042

1000

446

62-014256  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

VS 300  
Rev. 4/59

15117  
2 5117<sub>2</sub>

3

4 0

5 1

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7 1

8 2

9 4201

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12 2-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

M.E. Grimes, Medical Certification

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>13 years</b>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Methodist Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3209 Doniphan</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ALONZO</b> Last <b>MILLS</b>			4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1962</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/1899</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Co.</b>	9. AGE (last birthday) <b>62</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>French Lick, Ind.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Benjamin Mills</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Gass</b>	14. NAME OF HUSBAND OR WIFE <b>Mattie L.</b> Address <b>St. Joseph, Mo.</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>unknown</b>	17. INFORMANT <b>Mrs. Mattie L. Mills, 3209 Doniphan,</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 coronary occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Insufficiency</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) <b>Essen. hypertension</b> 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			INTERVAL BETWEEN ONSET AND DEATH <b>12-24 hr</b> <b>2 mo</b>
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 <b>Apr 2</b> to <b>Apr 19 62</b> and last saw him alive on <b>4-18-62</b> Death occurred at <b>6:05 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>M.E. Grimes</b> (Degree or title) _____		22b. ADDRESS <b>St Joseph Mo</b>	22c. DATE SIGNED <b>4-20-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4/21/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	23d. LOCATION (City, town, or county) <b>Excelsior Springs, Mo.</b> (State)
24. FUNERAL DIRECTOR <b>Heaton-Bauman</b> ADDRESS <b>St. Joseph, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>April 23 1962</b>	26. REGISTRAR'S SIGNATURE <b>Ms. Clark Woodell</b>

**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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 519 South St. Joseph, 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.