

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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FEB 18 1931

1. PLACE OF DEATH  
 County Cooper Registration District No. 225  
 Township Saline Primary Registration District No. 4138  
 City Woodruff Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Charles P. Mills  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. 675  
 Registered No. 3

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male  
 4. COLOR OR RACE white  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Roxie Mills

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9 - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 6 21

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER John Jacob Mills

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Roxie Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Wm Kasper  
 (Address) Woodruff Mo

15. FILED Feb 1, 1931 W. E. Neeker  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 30 1931

17. I HEREBY CERTIFY, That I attended deceased from 10 20 1931, to 1 - 28 1931, and that I last saw him alive on 1 - 28 1931, and that death occurred, on the date stated above, at 4 P m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Central Pneumonia  
apoplexy  
 (duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Senility  
 (duration) 1 yrs. 1 mos. ds.

18. WHERE AND DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) A. K. Umbreit M. D.  
1 - 3, 1931 (Address)

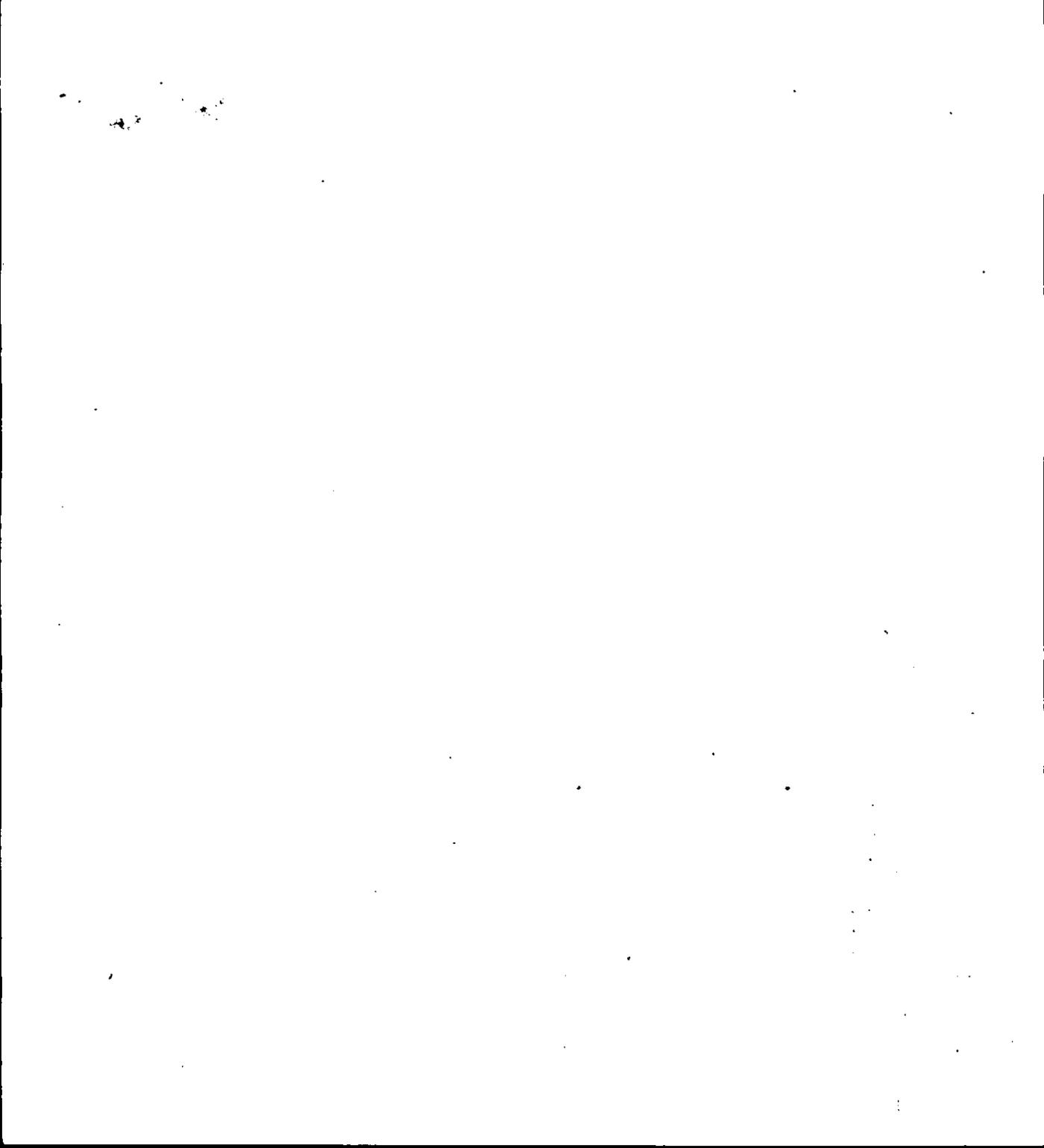
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
Coppleshappel Cem 2 - 1 1931

20. UNDERTAKER ADDRESS  
C. Albert Hornbeck Prairie Home

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ma



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cooper  
Township.....  
City Woodruffe (No.....)

Registration District No. 225-  
Primary Registration District No. 4138

File No. ....  
Registered No. 3  
St. .... Ward)

**2. FULL NAME**

Charles T. Mills

(a) Residence, No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 9 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 X 6 21

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19.....

19. UNDERTAKER (ADDRESS) .....

20. FILED Mar 7 1931 W E Kasper Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 30 1931

22. I HEREBY CERTIFY, That I attended deceased from ..... to .....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

**SUPPLEMENTARY**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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