S. No. 2
—11-10-39
v. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 23 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31251

Registration District No. 1 Primary Registration District No. 1 Registrar's No. 234

1. PLACE OF DEATH:

1 (a) County Adair

2 (b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)

2 (c) Name of hospital or institution: A. S. O. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days 1 (Specify whether
In this community 51 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Brashear.
(If outside city or town limits, write "RURAL")

0 (d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME JAMES RAY MILSTEAD.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married divorced Married

6. (b) Name of husband or wife Alma Milstead

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased June (Month) 15" (Day) 1888 (Year)

8. AGE:

Years	Months	Days	If less than one day
51	3	19	hr. min.

9. Birthplace Brashear (City, town, or county) mo. 0 (State or foreign country)

10. Usual occupation Rural Mail Carrier 0

11. Industry or business same 1

FATHER
12. Name Robt L. Milstead
13. Birthplace Ray Co. (City, town, or county) mo. (State or foreign country)

MOTHER
14. Maiden name Margaret Davidson
15. Birthplace (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Mrs Alma Milstead
(b) Address Brashear, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct (Month) 6" (Day) 40 (Year)
(c) Place: burial or cremation Brashear Cemetery

18. (a) Signature of funeral director Foster R. Easley
(b) Address Brashear, Mo.

19. (a) Oct. 8/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4" year 1940 hour 4 minute — A M.

21. I hereby certify that I attended the deceased from Oct 2, 1940, to Oct 4 —, 1940 that I last saw him alive on Oct 4 —, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis (non-specific)

Due to secondary to abdominal

~~Due to~~ peritonitis

Other conditions 117 W
(Include pregnancy within 3 months of death)

Major findings: Of operations Perforated gastric ulcer
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
3 While at work? (e) Means of injury

23. Signature R. R. Ellis (M. D. or other) 1
Address Kirksville, Mo. Date signed 10/5/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-40-2012
Date Filed

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 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Foster P. Easley
Licensed Embalmer No. 1146
P. O. Address Bracken, 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 this body is not embalmed, above space should be left blank.