

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Jackson City Mo.
 (c) Name of hospital or institution:
North east Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
 (Specify whether
 In this community 33 yrs
 years, months or days)

3. (a) PRINT FULL NAME Mildred L. Southard8. (b) If veteran, name war no 8. (c) Social Security No. no4. Sex Fem. 5. Color or race wh 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Walter F. Southard 6. (c) Age of husband or wife if alive 35 years7. Birth date of deceased June 6 1906
(Month) (Day) (Year)8. AGE: Years 34 Months 5 Days 19 If less than one day hr. min.9. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business

12. Name Edward Ward13. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)14. Maiden name Eppie Stone15. Birthplace Springfield Mo.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Walter F. Southard(b) Address Harrisonville Mo.17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-40
(Month) (Day) (Year)(c) Place: burial or cremation Springfield Mo.18. (a) Signature of funeral director John P. Sheil(b) Address 6606 Independence19. (a) 11-25-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass
 (c) City or town Harrisonville Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 404 So Independence
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25
year 1940 hour 6 minute P. M.21. I hereby certify that I attended the deceased from
Nov 16, 1940, to Nov 25, 1940
that I last saw her alive on Nov 25, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Chronic Myocarditis Duration 5 yrs
Due to Causes UnknownDue to ABC
Other conditions Anasarca & ascites
(Include pregnancy within 3 months of death)PHYSICIAN
Major findings:
Of operations
Of autopsy
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?

While at work? (Specify type of place)
 (e) Means of injury
 23. Signature D. Frank Clay (M. D. or other)
 Address 4316 E 9th St. Date signed 11-25-40

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 John P. Schul
Licensed Embalmer No. 3625

P. O. Address.....

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.