2
43
39
35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1601

State File No. 484

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Hyde Park Moving Co - 21 W. Linwood (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 25 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 2718 Troost (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

3. (a) PRINT FULL NAME Fred. Mills

3. (b) If veteran, name war no

3. (c) Social Security No. 496-01-1532

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Clara Mills

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Nov - 24 - 1890 (Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days 4 If less than one day ✓ hr. ✓ min.

9. Birthplace St Joseph Mo 0 (City, town, or county) (State or foreign country)

10. Usual occupation Furniture Moved

11. Industry or business Hyde Park Moving Co

FATHER
12. Name Geo Washington Mills
13. Birthplace Illinois 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary E. Palmer
15. Birthplace St. Joseph Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Fred Thompson

(b) Address 3035 Harrison

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31 - 44 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn ~~Florial Hill~~ Cem

18. (a) Signature of funeral director A. P. Doehler

(b) Address 1415 East 15

19. (a) Jan 29 1944 (Date received local registrar) (b) T E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-28 day year 1944 hour 10 minute a M.

21. I hereby certify that I attended the deceased from Jan 24 Jan 28 1944 to 1944 that I last saw him alive on Jan 24 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Heart disease mitral valve leak & dilated heart

Due to Perhaps rheumatism

Due to It was chronic & of months past affection

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Dilated heart (myocarditis) + valve leaking

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? no injury (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)

While at work? (e) Means of injury

23. Signature B. F. Shepherd M.D. (M. D. or other)

Address 2626 Troost Date signed 1-28-44

(Licensed Embalmer's Statement on Reverse Side)

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. W P L Doehler

Licensed Embalmer No. 1166

P. O. Address 1415 E 15

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.