S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4034

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 313

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Two days (Specify whether years, months or days) In this community 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County DeKalb
(c) City or town Osborn, Mo. (If outside city or town limits, write "RURAL")
Street No. — (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elizabeth Ann Milligan
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 28 (Day) 1940 (Year)

8. AGE: Years 7 Months 0 Days 9 If less than one day hr. min.

9. Birthplace Osborn (City, town, or county) Missouri (State or foreign country)
10. Usual occupation None
11. Industry or business
MOTHER FATHER
12. Name Ira G. Milligan
13. Birthplace Iowa! (City, town, or county) (State or foreign country)
14. Maiden name Bertha E. Sell
15. Birthplace DeKalb Co (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Ira Milligan
(b) Address Osborn Mo.
17. (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof Mar 10 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Osborn Cemetery
18. (a) Signature of funeral director F. G. Lyon
(b) Address St. Joseph Mo
19. (a) 3-10-47 (Date received local registrar) (b) H. E. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 7 year 1947 hour 8 minute 48 P.M.
21. I hereby certify that I attended the deceased from 1941, 19..., to 3-7, 1947 that I last saw h. alive on 3-7, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pelinesum	Long
Mongolism?	Lifetime
Due to Tonsillectomy & adenoidectomy	3-7-47
Due to Temp recent to 107 5 hrs after operation	
Other conditions (Include pregnancy within 3 months of death) No hemorrhage	
Major findings: Of operations Enlarged Thymus?	
Of autopsy Refused	

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)
While at work? (e) Means of injury
23. Signature L. C. Lemon M.D. (M. D. or other)
Address St. Joseph Mo Date signed 3-7-47

(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 F. G. Lyons

Licensed Embalmer No. 952

P. O. Address Stewartsville 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, fact should be so stated above.