Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-021017
STATE FILE NUMBER

FILED JUL 14 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 714

1. PLACE OF DEATH a. COUNTY Buchanan	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Joseph — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Joseph 0117 0 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Mo. Meth. Hosp. — Length of stay in lb 55 Years	d. STREET ADDRESS (If outside, give location) 804 Pendleton St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First: Mary	Middle: Bell	Last: Mills	4. DATE OF DEATH Month: July Day: 2, Year: 1958
5. SEX: Female 3	6. COLOR OR RACE: Negro	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: May 25, 1881	9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (City and state or country): Miami, Missouri 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: James Toliver	13b. MOTHER'S MAIDEN NAME: Martha Phillips	14. NAME OF HUSBAND OR WIFE: John Thomas Mills		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT Address: Mrs Ruby Smith, 1106 Paseo, K.C.Mo.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6/30/58, to 7/2/58 and last saw her/him alive on 7/1/58

Death occurred at 7:10 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Arvin W Oleung M.D. 0

22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.

22c. DATE SIGNED 7/3/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: July 5, 1958	23c. NAME OF CEMETERY OR CREMATORY: Ashland Cemetery	23d. LOCATION (City, town, or county) (State): St. Joseph, Mo.
24. FUNERAL DIRECTOR: Wm. H. Alexander	ADDRESS: St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG.: July 3, 1958	26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Wm. H. Alexand

Licensed Embalmer No. 4450

P. O. Address St. Joseph

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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