

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001530

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DATE AMENDED

AMENDED

FILED VS. JAN 30 1961

149

Primary Registration District No. 1002 Registrar's No. 185

185

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>50 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5805 St. John</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5805 St. John</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN ROBERT MILBY</u>				4. DATE OF DEATH Month Day Year <u>1 - 10 - 1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-29-1884</u>		
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baggage Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>K.C. Terminal</u>		11. BIRTHPLACE (City and state or country) <u>Nash Co. Ky</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>								
13a. FATHER'S NAME <u>Wilburn Milby</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			13c. NAME OF HUSBAND OR WIFE <u>Flora L. Milby</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 4-13-1905 - 4-12-1908</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Flora Milby K.C. Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>						<u>over 1 yr.</u>		
DUE TO (b) <u>Diabetes mellitus</u>						<u>6 mos.</u>		
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>1-2-61</u> to <u>1-10-61</u> and last saw ^{him} alive on <u>1-9-61</u> Death occurred at <u>10:25</u> <u>9</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Wilson H. Miller M.D.</u>				22b. ADDRESS <u>3626 Indep. ave Kans. City 24, mo.</u>		22c. DATE SIGNED <u>1-11-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-13-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt morial</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>		
24. FUNERAL DIRECTOR <u>C.H. Blackburn & Son K.C. Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1-12-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
WILSON H. MILLER
ITEM NO. SHOULD READ

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 W. C. Rinne

Licensed Embalmer No. 4879

P. O. Address K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.