

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14934**

FILED **APR 20 1953**
23044

BIRTH NO. _____ REG. DIST. NO. **167** PRIMARY REG. DIST. NO. **3040** Registrar's No. **56**

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Livingston	
b. CITY OR TOWN Chillicothe		c. CITY OR TOWN Rural Wheeling Township	
c. LENGTH OF STAY (In this place) 1 day		d. STREET ADDRESS (If rural, give location) 6 miles Northwest of Wheeling	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital			

3. NAME OF DECEASED a. (First) Baby b. (Middle) _____ c. (Last) McMillen			4. DATE OF DEATH (Month) (Day) (Year) April 13, 1953		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH April 12, 1953		9. AGE (In years last birthday) 0		IF UNDER 1 YEAR: Months 0 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Chillicothe, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Paul Eugen McMillen		13b. MOTHER'S MAIDEN NAME Mary Lou Pridemore		14. NAME OF HUSBAND OR WIFE None	
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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'S SIGNATURE OR NAME Paul E. McMillen; RR #2; Wheeling, Mo. ADDRESS _____	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 2 hr
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia - Terminal Bronchitis		DUPLICATE OF (b) Congenital Deformities - Spina Bifida, Club Feet			DUPLICATE OF (c) 1 day
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 751X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from **Apr. 12, 1953**, to **Apr. 13, 1953**, that I last saw the deceased alive on **Apr. 14, 1953**, and that death occurred at **4 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Joseph G. Conrad M.D. (Degree or title)		23b. ADDRESS Chillicothe Mo		23c. DATE SIGNED Apr 14-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-15-53		24c. NAME OF CEMETERY OR CREMATORY Fairport	
24d. LOCATION (City, town, or county) Fairport, Missouri		(State) _____			

DATE REC'D BY LOCAL REG. 4-14-53		REGISTRAR'S SIGNATURE Frances B. Nell 171-C		25. FUNERAL DIRECTOR'S SIGNATURE Norman Funeral Home; Chillicothe, Mo. ADDRESS _____	
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(Licensed Embalmer's Statement on Reverse Side)

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

592
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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
Student Embalmer

Signed Edwin F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.