

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 27 1955

BIRTH NO. _____ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 3076 Registrar's No. 1471

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY OR TOWN <u>Nevada</u>		c. CITY OR TOWN <u>Nevada</u>	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) <u>1012 E. Allison St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1012 East Allison</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>John</u>	b. (Middle) <u>H.</u>	c. (Last) <u>McMillin</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9-19-55</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>3-26-1878</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
<u>Retired Hospital Worker</u>	<u>Welder</u>	<u>Cedar County, Mo.</u>	<u>U.S.A.</u>

13a. FATHER'S NAME <u>McMillin</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Hart</u>	14. NAME OF HUSBAND OR WIFE <u>Audie Irene McMillin</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Audie I. McMillin</u>	ADDRESS <u>Nevada, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Angina Pectoris</u>		
	DUE TO (c) <u>none</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>4202</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Nevada - Vernon - Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>no injury</u>
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22. I hereby certify that I attended the deceased from Aug 1, 1955 to Sept 19, 1955, that I last saw the deceased alive on Sept 19, 1955, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. Steve [Signature]</u>	(Degree or title) <u>Dr.</u>	23b. ADDRESS <u>Nevada, Mo</u>	23c. DATE SIGNED <u>9-21-55</u>
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24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-21-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mound Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cedar County, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>9-21-55</u>	REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>	451	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Steve [Signature]</u>	ADDRESS <u>Nevada, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *Max W. Siskering*

Licensed Embalmer No. *F. 6.*

P. O. Address *W. D. ...*

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.