

FILED APR 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 157

Health, Welfare, Public Service

300
1-56

securing the medical certification in the specific manner required by 193.140 words 1947.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkville, Missouri</u>		c. CITY OR TOWN <u>Hurdland, Missouri</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grim Smith Hospital</u>		d. STREET ADDRESS <u>0520</u> (If outside, give location)	
Length of stay in hospital <u>10 hours</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Harold</u> Last <u>Mills</u>			4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-1904</u>
9. AGE (In years last birthday) <u>51</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Hurdland, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Thomas Mills</u>	
14. MOTHER'S MAIDEN NAME <u>Taylor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. <u>492-42-6890</u>		17. INFORMANT Address <u>Grim Smith Hospital Record-Kirkville, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot Wound to head</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted gunshot wound to head.</u>		
20c. TIME OF INJURY Hour <u>4</u> p. m. Month, Day, Year <u>4-22-57</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Hurdland</u>	COUNTY <u>Knox</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>4-22-57</u> to <u>4-23-57</u> and last saw ^{how} him alive on <u>4-22-57</u> Death occurred at <u>2:49</u> a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Kirkville, Mo.</u>	22c. DATE SIGNED <u>4-23-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-25-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hurdland</u>	23d. LOCATION (City, town, or county) (State) <u>Hurdland, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>[Signature] Edina, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-24-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

(Licensed Embalmer's Statement on Reverse Side)

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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 A. G. Primer, Student Embalmer No. 54 working under my personal supervision..

Student A. G. Primer
Signature of Student Embalmer

Signed Mrs J. W. Hudson

Licensed Embalmer No. 297

P. O. Address Edina

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.