

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018356  
STATE FILE NUMBER  
2132

FILED MAY 19 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2132

S. 300  
y. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen'l Hosp. #1</b>		Length of stay in lb. <b>LIFE 70 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>4011 WOODLAND AVE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert W. McMillen</b>			4. DATE OF DEATH Month Day Year <b>4 23 1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 18, 1877</b>
9. AGE (In years last birthday) <b>80</b>		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) <b>RETIRED STONE MASON</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>GRANDVIEW, MISSOURI</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>MICHAEL G. McMILLEN</b>	
13b. MOTHER'S MAIDEN NAME <b>VINALA BURRIS</b>		14. NAME OF HUSBAND OR WIFE <b>HATTIE McMILLEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>493-12-8900</b>	17. INFORMANT Address <b>MRS. MYRTIE J. BURCH, SHAWNEE, KANSAS</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4917</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> 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 <b>April 3, 1958</b> to <b>April 23, 1958</b> and last saw him alive on <b>April 23, 1958</b> Death occurred at <b>1:03 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert Burns, M.D.</b>		22b. ADDRESS <b>24th &amp; Cherry</b>	22c. DATE SIGNED <b>4-24-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>APRIL 26, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>D.W. NEWCOMER'S SONS, KANSAS CITY, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4-26-58</b>	26. REGISTRAR'S SIGNATURE <b>neva Marshall</b>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

B. I. Burns MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE



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 *Gerold E. Lettman*

Licensed Embalmer No. *3035*

P. O. Address *St. Paul*

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.