

Dr. Lurie
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043559

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1699 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

FILED DEC 9 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 8 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1942 S. KINGS Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN T. MILLS			4. DATE OF DEATH Month Day Year DEC. 1 1963
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/17/80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY C.B. & Q. R.R.	9. AGE (last birthday) 83 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) CAMERON, ILL.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME CHARLES D. MILLS		13b. MOTHER'S MAIDEN NAME SARAH A. WHITMAN	14. NAME OF HUSBAND OR WIFE NINA MILLS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. NINA MILLS,		Address SPRINGFIELD, MO.	
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>Rupture of Abdominal Aneurysm</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
DUE TO (b) <u>Arteriosclerosis</u>			<u>6 year</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) <u>Arteriosclerotic Heart Disease</u>			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 -Month, Day, Year a.m. p.m.			
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>12-1-63</u> to <u>12-1-63</u> and last saw ^{her} him alive on <u>12-1-63</u> Death occurred at <u>10:10 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul R. Owen MD</u>		22b. ADDRESS <u>605 Lexington Springfield Mo</u>	22c. DATE SIGNED <u>12-3-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12/6/63	23c. NAME OF CEMETERY OR CREMATORY GRANDVIEW	23d. LOCATION (City, town, or county) (State) HANNIBAL, MO.
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 12-4-63	26. REGISTRAR'S SIGNATURE <u>Bernie Medley</u>

USE BLACK INK OR TYPEWRITER RIBBON

DEC 11 1963

12/11/63

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

James T. Dudley

Licensed Embalmer No. 4815

P. O. Address Springfield, 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.