

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30339**
4009

FILED SEP 29 1951

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>3 weeks</u>		c. CITY OR TOWN <u>Slater</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mabel</u> b. (Middle) <u>Demotte</u> c. (Last) <u>McMULLEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9-20-51</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>1-27-1881</u>		9. AGE (in years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Green County, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ernory Demotte</u>		13b. MOTHER'S MAIDEN NAME <u>Martha E. Kimberston</u>		14. NAME OF HUSBAND OR WIFE <u>John T. McMillen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>M. John T. McMillen</u> ADDRESS <u>SLATER MO.</u>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PULMONARY ATELECTASIS</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPOSTATIC CONGESTION & PNEUMONIA, KYPHOSCOLIOSIS</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>MYOCARDIAL FIBROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
19a. DATE OF OPERATION <u>8/21/51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Gall stone in terminal ileum</u> <u>ACUTE OBSTRUCTION TERMINAL ILEUM</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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 <u>Pathologist</u> , 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:42</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>W. R. McShree</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Research Hospital 23rd Holme</u>		23c. DATE SIGNED <u>9/20/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>General</u>		24b. DATE <u>5-9-20-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Great Bend</u>		24d. LOCATION (City, town, or county) (State) <u>Great Bend, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-20-51</u>		REGISTRAR'S SIGNATURE <u>Seraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ms. C. L. Foster</u>		ADDRESS <u>R.C. Mo</u>	

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Gen Clark

Licensed Embalmer No. *4216*

P. O. Address *K. S. 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.