

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

39971  
STATE FILE NUMBER  
Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1084-A

FILED NOV 25 1957

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</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>BURGE HOSPITAL</b>		Length of stay in 1b <b>18 yrs</b>	d. STREET ADDRESS <b>1044 W. Walnut</b>		(If outside, give location) <b>2376</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RUBY</b> Middle <b>IRENE</b> Last <b>McMILLIN</b>			4. DATE OF DEATH <b>November 6, 1957</b> Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1920</b>	9. AGE (In years last birthday) <b>37</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>Egg Candler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Producers Produce Co. Pittsburgh, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Newton McMillin</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah E. Talbot</b>		14. NAME OF HUSBAND OR WIFE <b>* * * * *</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <b>NO</b> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Mrs. Sarah McMillin, 1044 W. Walnut</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>about 9 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.					DUE TO (b) <b>Epileptic seizure</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) - <b>Pneumonia</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <b>NOT KNOWN</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Not known, but presumably from fall at onset of</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. <b>Probably 1 p.m. 11-6-57</b>		20d. INJURY OCCURRED: WHILE AT <input type="checkbox"/> NOT WHILE WORK AT WORK <input checked="" type="checkbox"/> <b>convulsions.</b>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Springfield</b>		COUNTY <b>Greene</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>4:45 pm 11-6-57</b> to <b>5 pm 11-6-57</b> and last saw her alive on <b>5:30 pm 11-6-57</b> Death occurred at <b>10:00 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert P. Simpson, M.D.</b> (Degree or title)			22b. ADDRESS <b>301 Springfield Medical Building Springfield, Mo.</b>		22c. DATE SIGNED <b>11-8-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/9/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sinking Creek Cemetery</b>		23d. LOCATION (City, town, or county) <b>Everton, Missouri</b> (State)
24. FUNERAL DIRECTOR <b>AYRE-GOODWIN, Inc. Springfield</b>			ADDRESS <b>11-22-57</b>	25. DATE RECD. BY LOCAL REG. <b>11-22-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Lillian T. Lively* .....

Licensed Embalmer No. *4875* .....

P. O. Address *.....*

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.