

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-040640**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 367

VS 300  
Rev. 4/59

1 0648

2 0648

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9 951x

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11 119

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Hannibal</u> Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Leveing Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3819 Rhodes Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin Eugene Millidge</u>			4. DATE OF DEATH Month Day Year <u>Oct 9, 1963</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26, 37</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>37</u>
11a. FATHER'S NAME <u>Charles J Millidge</u>		11b. MOTHER'S MAIDEN NAME <u>Zola Burch</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes Korea</u>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:		17. INFORMANT <u>Charles Millidge - Hannibal, Mo</u> Address	
IMMEDIATE CAUSE (a) <u>Anaphalactic Shock</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
DUE TO (b) <u>Penicillin Reaction</u>		<u>1/2 hr</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)		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Received shot of penicillin, immediately</u>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>had anaphalactic reaction</u>	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	20g. COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>10:45 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Samuel H. Wood Jr. MD Coroner</u>		22b. ADDRESS <u>Hannibal Mo</u>	22c. DATE SIGNED <u>10/10/63</u>
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 12, 63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo</u>
24. FUNERAL DIRECTOR <u>Blair Funeral Home - Hannibal, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 10, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. ... by ... M. Kerman</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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ralph Clark

Licensed Embalmer No. 4217

P. O. Address Hammond, 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.

Permit issued 10/10/63