

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18810  
Registrar's No. 219

FILED JUL 9 1949

BIRTH NO. REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo 8888		b. COUNTY Boone	
b. CITY OR TOWN Fulton		c. LENGTH OF STAY (in this place) 21 mo		c. CITY OR TOWN Thompson	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No 1				d. STREET ADDRESS /	

3. NAME OF DECEASED (Type or Print) Millie			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 6 27 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 4-15-1870			9. AGE (In years last birthday) 79	IF UNDER 1 YEAR 2 Months	IF UNDER 12 HRS. 12 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Mo. U		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Tam Sewall		13b. MOTHER'S MAIDEN NAME Mary Hawkins		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) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Hospital records, State Hospital	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senile psychosis				UNKNOWN	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) General arteriosclerosis					
		II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. DUE TO (c)					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 6-15-49, 19\_\_, to 6-27-49, 19\_\_, that I last saw the deceased alive on 6-27-49, 19\_\_, and that death occurred at 11:50 pm., from the causes and on the date stated above.

23a. SIGNATURE <i>M J Miller</i>		(Degree or title)		23b. ADDRESS State Hospital, Fulton, Mo		23c. DATE SIGNED 6-27-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 6-27-49		24c. NAME OF CEMETERY OR CREMATORY NEAR PARIS		24d. LOCATION (City, town, or county) (State) PARIS, MO.	

DATE REC'D BY LOCAL REG. June 27-1949		REGISTRAR'S SIGNATURE <i>Maretha Lawrence</i>		426		25. FUNERAL DIRECTOR'S SIGNATURE <i>Spencer Blaney</i>		ADDRESS Paris, Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
JUL 6 1949  
District Health Officer No. 9,  
District File Number-----

**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 .....  
Student Embalmer

Signed..... *E. S. Ryan*

Licensed Embalmer No. 4000

P. O. Address..... Paris, 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.