

FILED AUG 1 1949

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22625

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 824

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Savannah - Rural</b>	
c. LENGTH OF STAY (In this place) <b>1 day</b>		d. STREET ADDRESS (If rural, give location) <b>R.F.D. # 2</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Missouri Methodist Hosp.</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>ANNA</b>	b. (Middle) <b>ELIZABETH</b>	c. (Last) <b>MILLER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>7 25 1949</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>11-20-1949</b>	9. AGE (In years last birthday) <b>64</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Stewartsville, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>William V. Lisle</b>	13b. MOTHER'S MAIDEN NAME <b>Laura L. James</b>	14. NAME OF HUSBAND OR WIFE <b>Frank Miller</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Frank Miller, Savannah, Missouri</b>

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Arteriosclerosis</b> <b>anginal pectoris</b> ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 yrs.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>				<b>42</b>

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 July 25, 1949, to July 25, 1949, that I last saw the deceased alive on July 25, 1949, and that death occurred at 8:30 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Harold J. Brennan, M.D.</b>	23b. ADDRESS <b>St Joseph, Mo</b>	23c. DATE SIGNED <b>7-27-49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-29-1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>
		24d. LOCATION (City, town, or county) (State) <b>Savannah, Missouri</b>

DATE REC'D BY LOCAL REG. <b>July 28, 1949</b>	REGISTRAR'S SIGNATURE <b>E. B. Jenkins</b>	382	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John E. Cripp, St. Joseph, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*John E. Rupp*  
Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.