

FILED DEC 12 1950

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36530  
0710

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 30157 Registrar's No. 120

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>COOPER</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>MOYGAN</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Boonville</u>                          |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>RURAL BUFFALO TWP</u>   |  |
| c. LENGTH OF STAY (In this place)<br><u>5 weeks</u>   |  | d. STREET ADDRESS (If rural, give location)<br><u>8 Miles South of Stover</u>  |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location)<br><u>St Joseph Hospital</u> |  |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>JOHN</u> b. (Middle) _____ c. (Last) <u>Miles</u>     |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Dec 2 1950</u> |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>                          |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u> |  |
| 8. DATE OF BIRTH<br><u>April-18-81</u>  |  | 9. AGE (In years last birthday) <u>69</u>              |  | 10. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farming</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm Owner</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Huntville, Mo.</u>       |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME<br><u>TOM L Miles</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Sarah Reeds</u> |  | 14. NAME OF HUSBAND OR WIFE<br><u>Eddie Miles</u>                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> |  | 16. SOCIAL SECURITY NO.<br><u>None</u>          |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Mrs Eddie Miles Stover, MO</u> |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolus</u>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH.<br><u>20 minutes</u>                              |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Pulmonary Infarction</u>       |  |  |  |   |  |
|   |  | DUE TO (c) <u>Thrombo-Phlebitis, R. leg</u>   |  |  |  |   |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>1st Stage Prostatectomy</u> |  |  |  | <u>332X</u>   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  |  |  | 20. AUTOPSY?<br>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 checked="" type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                      |  |

22. I hereby certify that I attended the deceased from 11/2/50, 1950, to 12/2, 1950, that I last saw the deceased alive on 12/2, 1950, and that death occurred at 7:21 Pm., from the causes and on the date stated above.

|   |  |                                      |  |                                    |  |
|---|--|--------------------------------------|--|------------------------------------|--|
| 23a. SIGNATURE (Degree or title)<br><u>E. T. Humphreys M.D.</u> |  | 23b. ADDRESS<br><u>Boonville, Mo</u> |  | 23c. DATE SIGNED<br><u>12-3-50</u> |  |
|---|--|--------------------------------------|--|------------------------------------|--|

|   |  |                             |  |                                    |  |   |  |
|---|--|-----------------------------|--|------------------------------------|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> |  | 24b. DATE<br><u>12/2/50</u> |  | 24c. NAME OF CEMETERY OR CREMATORY |  | 24d. LOCATION (City, town, or county) (State)<br><u>Stover - Mo</u> |  |
|---|--|-----------------------------|--|------------------------------------|--|---|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| DATE REC'D BY LOCAL REG.<br><u>12-3-50</u> |  | REGISTRAR'S SIGNATURE<br><u>D. Hooper 381</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>J. L. Steverson Stover, Mo</u> |  |
|--|--|---|--|---|--|

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

12-11-50

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 12-11-50

DEC 12 1950

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 \_\_\_\_\_

*J.R. Scrimmer*

working under my personal supervision.

Student Embalmer No. 404

Signed *J.R. Scrimmer*  
Student Embalmer

Signed *J. H. Stevenson*  
Licensed Embalmer No. 4073

P. O. Address Stover, 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.