

FILED OCT 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30000
844

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1021 W. DIVISION		d. STREET ADDRESS (If rural, give location) 1021 W. DIVISION	

3. NAME OF DECEASED (Type or Print)	a. (First) LULA	b. (Middle) SARAH	c. (Last) MILLER	4. DATE OF DEATH OCT. 1 1951
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH NOV. 11 1870	9. AGE (In years last birthday) 80	# UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY IN HOME	11. BIRTHPLACE (State or foreign country) MISSOURI 0	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED
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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. NO	17. INFORMANT'S SIGNATURE OR NAME ADDRESS WARREN MILLER SPRINGFIELD
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial insufficiency		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-7, 19 48, to 9-30, 19 51, that I last saw the deceased alive on 9-30, 19 51 and that death occurred at 5:30a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. Allen Puckens, M.D.	23b. ADDRESS 407 Medical Arts Bldg.	23c. DATE SIGNED 10-1-51
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24a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Oct. 3-1951	24c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY	24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MISSOURI
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DATE REC'D BY LOCAL REG. 10-2-51	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. Klingman & Co
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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.....

Max Rhodes
Licensed Embalmer No. 4071
P. O. Address Springfield

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.