

REC'D OCT 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34587**

BIRTH NO. _____ REG. DIST. NO. **275** PRIMARY REG. DIST. NO. **3053** Registrar's No. **182**

1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ph	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rolla		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
c. LENGTH OF STAY (in this place) 3 yrs.		d. STREET ADDRESS (If rural, give location) 4657 Delmar Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION McFarland Nursing Home			

3. NAME OF DECEASED (Type or Print) a. (First) MOLLEY	b. (Middle) E.	c. (Last) MILLS	4. DATE OF DEATH (Month) (Day) (Year) Oct. 10, 1951
---	-----------------------	------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 11, 1863	9. AGE (in years last birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 12 HRS. Hours	IF UNDER 12 HRS. Min.
----------------------	-------------------------------	--	---------------------------------------	---	---------------------------	--------------------------	---------------------------	--------------------------

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) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	--	---

13a. FATHER'S NAME W. E. Bray	13b. MOTHER'S MAIDEN NAME Sarah Gregory	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. None	17. INFORMANT'S SIGNATURE OR NAME Hospital records	ADDRESS
---	--	--	---------

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH yes?
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-sclerosis, far advanced		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fractured hip.		Sept 13, 51	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4500 F	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) m.	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 **Sept 13, 1951**, to **Oct 10, 1951**, that I last saw the deceased alive on **Oct 2nd, 1951**, and that death occurred at **11 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE James M. Myers M.D.	23b. ADDRESS Rolla, Mo.	23c. DATE SIGNED 10-15-51
--	-----------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 14, 1951	24c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery	24d. LOCATION (City, town, or county) (State) Campbell, Missouri
--	-----------------------------------	--	--

DATE REC'D BY LOCAL REG. Oct. 16, 1951	REGISTRAR'S SIGNATURE Nadine L. Stoll	25. FUNERAL DIRECTOR'S SIGNATURE Paul E. Null	ADDRESS Rolla, Mo.
--	---	---	------------------------------

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

8912
4

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Paul E. Noll

Signed.....
Student Embalmer

Licensed Embalmer No. *4498*

P. O. Address _____

Rolla, 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.