

STANDARD CERTIFICATE OF DEATH

BIRTH NO. REG. DIST. NO. 212 PRIMARY REG. DIST. NO. 5779 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY Miller		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Miller	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - FRANKLIN 5423		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - FRANKLIN 0560	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3 mi S-E-ELDON		d. STREET ADDRESS (If rural, give location) 3 mi S-E-ELDON	

3. NAME OF DECEASED (Type or Print) a. (First) ANNA- b. (Middle) Ruth c. (Last) MILLER	4. DATE OF DEATH (Month) (Day) (Year) Oct-25 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 3 June 1898	9. AGE (In years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE	11. BIRTHPLACE (State or foreign country) Miller-Co-Mo	12. CITIZEN OF WHAT COUNTRY U.S.A
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE	10b. KIND OF BUSINESS OR INDUSTRY AT-Home	11. BIRTHPLACE (State or foreign country) Miller-Co-Mo	12. CITIZEN OF WHAT COUNTRY U.S.A
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Charles-Miller
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME Charles-Miller	ADDRESS ELDON Mo
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary left breast		
	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 none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) -	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none
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22. I hereby certify that I attended the deceased from June 1951, to Oct 25, 1951, that I last saw the deceased alive on Oct 25, 1951, and that death occurred at 4:35 P.m., from the causes and on the date stated above.

23a. SIGNATURE E O Sheeton M.D. (Degree or title)	23b. ADDRESS ELdon - Mo	23c. DATE SIGNED 27 Oct 51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 28 Oct 51	24c. NAME OF CEMETERY OR CREMATORY ELdon	24d. LOCATION (City, town, or county) (State) ELdon Mo
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DATE REC'D BY LOCAL REG. Oct. 27, 51	REGISTRAR'S SIGNATURE Alvaretta Walt	192	25. FUNERAL DIRECTOR'S SIGNATURE Ruth M Kaye	ADDRESS ELdon Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

660

NOV 26 1950

DEPARTMENT OF HEALTH  
DEPARTMENT

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 Keith M. Kays

Licensed Embalmer No. 3998

P. O. Address Olden 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.