

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1952

BIRTH NO. _____		REG. DIST. NO. 53		PRIMARY REG. DIST. NO. 3010		Registrar's No. 25		
1. PLACE OF DEATH a. COUNTY CAPE GIRARDEAU				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE MO. b. COUNTY SCOTT				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CAPE GIRARDEAU		c. LENGTH OF STAY (in this place) 6 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CHAFFEE		1000		
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSP				d. STREET ADDRESS (If rural, give location) RD # 2				
3. NAME OF DECEASED (Type or Print) a. (First) EMMA b. (Middle) BELLE c. (Last) MILLER			4. DATE OF DEATH (Month) (Day) (Year) 1 16 1952					
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M		8. DATE OF BIRTH 6-7-1890	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 7 Days 9	IF UNDER 24 HRS. Hours Mins. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWOMAN		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME JACOB W. SMITH			13b. MOTHER'S MAIDEN NAME JESSIE CHILDERS		14. NAME OF HUSBAND OR WIFE EARL H. MILLER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mr. Earl H. Miller Chaffee				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hemorrhage Hemorrhage DUE TO (c) Chronic Cardiac Disease Conditions contributing to the death but not related to the disease or condition causing death. II. OTHER SIGNIFICANT CONDITIONS Chronic Arthritis					INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201				
22. I hereby certify that I attended the deceased from 1/10/52 , 19 52 , to 1/16 , 19 52 , that I last saw the deceased alive on 1/16 , 19 52 , and that death occurred at 2 a.m. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) W O Fumery MD				23b. ADDRESS 1921 1/2 Chaffee Mo		23c. DATE SIGNED 1/19/52		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 1-18-52		24c. NAME OF CEMETERY OR CREMATORY UNION PARK CEM		24d. LOCATION (City, town, or county) (State) CHAFFEE MO.		
DATE REC'D BY LOCAL REG. 1-20-52		REGISTRAR'S SIGNATURE C. C. Summers		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS M. Hubbs Chaffee Mo				

01640

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 _____

C. J. Loring

Licensed Embalmer No. 3810

P. O. Address Cape Girardeau, 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.