

FILED FEB 1 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2547

State File No.

BIRTH NO. <u>0810</u>		REG. DIST. NO. <u>276</u>		PRIMARY REG. DIST. NO. <u>5945</u>		Registrar's No. <u>6</u>	
1. PLACE OF DEATH a. COUNTY <u>Phelps</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Phelps</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Dillon, Mo.</u>		c. LENGTH OF STAY (in this place) <u>15 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. James, Mo. - (Rural)</u>		d. STREET ADDRESS (If rural, give location) <u>0810</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lottie</u>			b. (Middle) <u>Miller</u>			c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 25, 1953</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Feb 7, 1869</u>		9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dash Knaw</u>		13b. MOTHER'S MAIDEN NAME <u>Dash Knaw</u>		14. NAME OF HUSBAND OR WIFE <u>Bill Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Arch Webster - Dillon, Mo</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Influenza</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>480X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 day</u> <u>2 day</u>	
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?			
22. I hereby certify that I attended the deceased from <u>January 13, 1953</u> , to <u>January 25, 1953</u> , that I last saw the deceased alive on <u>Jan 25, 1953</u> , and that death occurred at <u>7:00 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>C.V. Hammel, M.D.</u> (Degree or title)				23b. ADDRESS <u>St. James, Mo</u>		23c. DATE SIGNED <u>1-26-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 28, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY: <u>Masonic Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. James, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-28-53</u>		REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Oral E. Lieplider St James</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

County of Hamilton, New York
Health Officer,
Date Filed 1-31-53

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

Carl E. Schickel

Licensed Embalmer No. 3546

P. O. Address St. James 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.