

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 15 1953

BIRTH NO. _____ REG. DIST. NO. **67** PRIMARY REG. DIST. NO. **2263** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY CHRISTIAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CHRISTIAN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL LINDEN TWP.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL LINDEN TWP.	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 0228	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) FRANCES b. (Middle) E. c. (Last) MILLER			4. DATE OF DEATH (Month) (Day) (Year) APRIL 28, 1953		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JAN. 6, 1876	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY SELF	11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME WILLIAM GRAY		13b. MOTHER'S MAIDEN NAME ROLLER		14. NAME OF HUSBAND OR WIFE TOM MILLER DEC.	
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 ADDRESS LORENE CHAFFIN ROGERSVILLE, MO.	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, cerebral		INTERVAL BETWEEN ONSET AND DEATH 3 HRS
	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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331x	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)	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 **4-11-1953** to **4-29-1953** that I last saw the deceased alive on **4-11-1953** and that death occurred at **7:00 a.m.**, from the cause and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 4-30-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-30-53	24c. NAME OF CEMETERY OR CREMATORY ROLLER CEMETERY	24d. LOCATION (City, town, or county) (State) CHRISTIAN CO. MISSOURI
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DATE REC'D BY LOCAL REG. June 12, 1953	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS
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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 _____

W. K. Lurell

Signed

Student Embalmer

Licensed Embalmer No. 4910

P. O. Address Ireland, 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.