

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43512**

FILED JAN 5 1954

BIRTH NO. _____ REG. DIST. NO. **176** PRIMARY REG. DIST. NO. **5654** Registrar's No. **38**

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

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Miller Lincoln	c. LENGTH OF STAY (In this place) 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Miller Lincoln	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If rural, give location) R.F.D. 0550	

3. NAME OF DECEASED (Type or Print) a. (First) Jessie b. (Middle) Whigham c. (Last) James	4. DATE OF DEATH (Month) (Day) (Year) 12-28-1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-6-1901	9. AGE (In years last birthday) 52 IF UNDER 1 YEAR Months 10 Days 22 IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Springfield Mo.	12. CITIZEN OF WHAT COUNTRY? Native
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13a. FATHER'S NAME Jasper James	13b. MOTHER'S MAIDEN NAME Whigham	14. NAME OF HUSBAND OR WIFE Mable James
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	16. SOCIAL SECURITY NO. 303-03-1715	17. INFORMANT'S SIGNATURE, OR NAME Mrs. Mable James Miller	ADDRESS Miller 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) atherosclerosis		
	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 4201	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.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____ 19____, to **Dec. 28**, 19**53**, that I last saw the deceased alive on **Dec. 27**, and that death occurred at **5:40 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clifford H. Jones M.D.	23b. ADDRESS Miller, Mo.	23c. DATE SIGNED Dec. 29, '53
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24a. BURIAL OR CREMATION REMOVAL (Specify) Removed	24b. DATE 12-29-53	24c. NAME OF CEMETERY OR CREMATORY Aurora Phillips	24d. LOCATION (City, town, or county) (State) Aurora Phillips
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DATE REC'D BY LOCAL REG. 12-30-53	REGISTRAR'S SIGNATURE W. S. Beebe	25. FUNERAL DIRECTOR'S SIGNATURE Leiman Miller	ADDRESS Miller Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

E. P. Linnon

Licensed Embalmer No. _____

3297

P. O. Address _____

Miller 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.