

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17659**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **388** PRIMARY REG. DIST. NO. **4510** Registrar's No. **22**

1. PLACE OF DEATH a. COUNTY <b>Sullivan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Sullivan</b>	
b. CITY OR TOWN <b>Osgood</b>	c. LENGTH OF STAY (In this place) <b>Life</b>	c. CITY OR TOWN <b>Osgood</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <b>1050</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ELIZABETH</b> b. (Middle) <b>MILNER</b> c. (Last) <b>MILNER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>5-7-1954</b>			
5. SEX <b>fe</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>6-10-1879</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Sullivan Co Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>W H Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Eliza Jackson</b>		14. NAME OF HUSBAND OR WIFE <b>S L Milner</b>	
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 <b>S L Milner</b> ADDRESS <b>Osgood Mo</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardio-Vascular-renal disease</b>			<b>2 years</b>
		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		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (a.s., 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 **May 1st, 1954** to **May 7th, 1954**, that I last saw the deceased alive on **May 4th, 1954** and that death occurred at **9:20 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Oliver F. Joffe</b> (Degree or title)		23b. ADDRESS <b>Centerville Mo</b>		23c. DATE SIGNED <b>May 9th 1954</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-9-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Union Grove Cem</b>	
24d. LOCATION (City, town, or county) <b>Osgood</b>		24e. (State) <b>Mo</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>PR Payne</b> ADDRESS <b>son Galt Mo</b>	
DATE REC'D BY LOCAL REG. <b>May 14-54</b>		REGISTRAR'S SIGNATURE <b>318-11 Brita Caldwell</b>			

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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 340

P. O. Address Salt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.