

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22167**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **850**

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>67 years</b>		e. STREET ADDRESS (If rural, give location) <b>1120 Main St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Memorial Home 1120 Main</b>			

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Mary</b> b. (Middle) <b>D.</b> c. (Last) <b>Miller</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>August 2, 1954</b>		
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<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>June 29, 1868</b>	<b>9. AGE</b> (In years last birthday) <b>86</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Shelbyville, Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>Samuel Darrah</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Philena Grogg</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Shelley F.</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Hobart Miller</b>	<b>ADDRESS</b> <b>139 Clairmonte, Syracuse, N.Y.</b>
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<b>18. CAUSE OF DEATH</b> 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.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>unknown</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)</b> <b>Cancer of Bladder + Metastasis</b>		
	<b>ANTECEDENT CAUSES</b> <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> <b>Bladder irritation</b>		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>			

<b>19a. DATE OF OPERATION</b> <b>7/15/54</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Cancer of Bladder</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>181X</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ m.	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from 4-1, 1952, to 8/2, 1954, that I last saw the deceased alive on 8/1, 1954, and that death occurred at 6:15a. m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <i>[Signature]</i> (Degree or title) <b>MD</b>	<b>23b. ADDRESS</b> <b>423 Main St., City</b>	<b>23c. DATE SIGNED</b> <b>8-2-54</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>	<b>24b. DATE</b> <b>8/4/1954</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Ashland Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>St. Joseph, Missouri</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>Aug 4, 1954</b>	<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>[Signature]</i>	<b>ADDRESS</b> <b>St. Joseph, Mo.</b>
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*W. E. Edmiston*

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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 .....; Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *W. E. Edmiston* .....

Licensed Embalmer No. *479*

P. O. Address *3195 10 St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.