

FILED JUL 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23084**
2918

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Wyannton Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wyannton Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>K.C. Mo Kansas</u>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>K.C. City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hosp.</u>		e. STREET ADDRESS (If rural, give location) <u>7418 Chestnut 3898</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary</u>	b. (Middle) <u>Emma</u>	c. (Last) <u>Miller</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6 26 54</u>
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5. SEX <u>Fe</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-21-78</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>(City unknown) Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>ALBERT BECKER</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH SMUTTER</u>	14. NAME OF HUSBAND OR WIFE <u>MARION MILLER</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. ROSIE LONG</u>	ADDRESS <u>LONG JACK, MO.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Vascular Hemorrhage 4 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>443X</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Card Vasc. Dis 2 yrs.</u>		
	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"/>
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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)	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 6-22, 1954, to 6-26, 1954, that I last saw the deceased alive on 6-26, 1954, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Lyman W. Lais</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>4316 Adams KC Mo</u>	23c. DATE SIGNED <u>6-26-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>6-29-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield Mo.</u>
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DATE REC'D BY LOCAL REG. <u>6-28-54</u>	REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.P. Sheil</u>	ADDRESS <u>K.C. Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Sheel

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 *John P. Sheel*.....

Licensed Embalmer No. *362*.....

P. O. Address *N.C. Ma*.....

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.