

FILED MAR 21 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8619**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 4249 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.) a. STATE <u>Mo</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Hellaboro</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>House Springs Mo RR#1</u>	
c. LENGTH OF STAY (If this place) <u>30 Days</u>		d. STREET ADDRESS (If rural, give location) <u>Murphy Cr</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cedar Grove Nursing Home</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) _____ c. (Last) <u>MILLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-8-1955</u>	
5. SEX <u>MO</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 5-1871</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>	IF UNDER 6 Wks. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Rock Creek Mo 0</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Nicholas Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Kirk</u>	14. NAME OF HUSBAND OR WIFE <u>Mary (Radetz) Miller</u>
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>Elizabeth Helbruegge</u> ADDRESS _____
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>  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 <u>Benign prostatic hypertrophy.</u> <u>unknown.</u> 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 (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 <u>Feb 14</u> , 19 <u>55</u> , to <u>March 8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 2</u> , 19 <u>55</u> , and that death occurred at <u>12:30 pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Thomas A. Donnell M.D.</u>		23b. ADDRESS <u>Dr. Soto One</u>	
23c. DATE SIGNED _____			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>3/11/55</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Rock Creek - Mo</u>	
DATE REC'D BY LOCAL REG. <u>3-12-55</u>		REGISTRAR'S SIGNATURE <u>Kathleen O'Grady</u> 141-0	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>		ADDRESS <u>House Springs Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

500  
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JEFFERSON COUNTY HEALTH DEPT.  
HILLSBORO, MISSOURI

DATE RECEIVED

MAR 17 1955

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

*John H. Brunner*

Licensed Embalmer No. 1470

P. O. Address. House Springs, 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.