

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20767

State File No.

FILED JUN 28 1955

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 30722 Registrar's No. 111

1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). b. STATE Missouri c. CITY OR TOWN Marshall d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall, Mo.		c. LENGTH OF STAY (in this place) 4Hrs.		c. CITY OR TOWN Marshall		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 Fitzgibbon Ho spital				e. STREET ADDRESS (If rural, give location) 1270 So. English						
3. NAME OF DECEASED (Type or Print) a. (First) Lorraine			b. (Middle) Ellen		c. (Last) Miller		4. DATE OF DEATH (Month) (Day) (Year) June 24 1955			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH July 22-1874		9. AGE (In years last birthday) IF UNDER 1 YEAR 80 Months 11 Days 2		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (City and State or Foreign Country) Marshall, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME George E. Farlow			13b. MOTHER'S MAIDEN NAME Mary P. Fellers			14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Walter L. Recks, Marshall, Mo.			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, ashenia, etc.: It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Asthma 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.				INTERVAL BETWEEN ONSET AND DEATH (Year) 4 days		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION 241X			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) (Min.)			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>June 20, 1955</u> , to <u>June 24, 1955</u> , that I last saw the deceased alive on <u>6/24, 1955</u> , and that death occurred at <u>12⁰⁰ noon</u> from the causes and on the date stated above.										
23a. SIGNATURE Robert Kennedy M.D.			(Degree or title)			23b. ADDRESS Marshall Mo		23c. DATE SIGNED 6-24-55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/26/55		24c. NAME OF CEMETERY OR CREMATORY Union Cemetery		24d. LOCATION (City, town, or county) (State) 6Mi.N.W.of Marshall, Mo.				
DATE REC'D BY LOCAL REG. 6-25-55		REGISTRAR'S SIGNATURE Chad L. Reed Deputy			385-0		25. FUNERAL DIRECTOR'S SIGNATURE J. Leslie Swanson - Marshall, Mo.		ADDRESS	

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.....
J. Leahy

Licensed Embalmer No...*337*

P. O. Address...*Marsh*

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.