

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29618**

FILED SEP 20 1955

BIRTH NO. **49699-55** REG. DIST. NO. **1412** PRIMARY REG. DIST. NO. **4231** Registrar's No. **25-**

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

1. PLACE OF DEATH a. COUNTY Hawaii		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE MO b. COUNTY Shannon	
b. CITY OR TOWN Alii View (If outside corporate limits, write RURAL and give township)		c. CITY OR TOWN Summersville	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital		e. STREET ADDRESS (If rural, give location) 10101	
3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) -Wayne- (Last) Miller		4. DATE OF DEATH (Month) (Day) (Year) Aug-17-1956	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Aug-3-1956
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION		11. BIRTHPLACE (City and State or Foreign Country) Alii View MO	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Rae Miller		13b. MOTHER'S MAIDEN NAME Leatrice Medina	
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)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Rae Miller Summersville	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Blue Baby (Formerly Deaf) INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Failed To Close 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 7543!	
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 8-3 , 19 55 , to 8-17 , 19 56 , that I last saw the deceased alive on 8-16 , 19 55 , and that death occurred at 6:00 p.m., from the causes and on the date stated above.			
23a. SIGNATURE James R. Shaffer - D.O.		23b. ADDRESS Alii View MO	
23c. DATE SIGNED 9-16-56		23d. (Degree or title)	
24a. BURIAL, CREMATION, REMOVAL (Specify) B.		24b. DATE 8-19-56	
24c. NAME OF CEMETERY OR CREMATORY City		24d. LOCATION (City, town, or county) (State) Summersville MO	
DATE REC'D BY LOCAL REGISTRY 9-17-56		REGISTRAR'S SIGNATURE Laura Mitchell	
FUNERAL DIRECTOR'S SIGNATURE Duncan's		ADDRESS Alii View MO	

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

Nat Embalmer

Signed *Low R. Duncan*

Licensed Embalmer No. *432*
P. O. Address *Mt. View*

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.