

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40330

State File No. ....

FILED DEC 20 1955

BIRTH NO. _____		REG. DIST. NO. <u>139</u>		PRIMARY REG. DIST. NO. <u>5531</u>		Registrar's No. <u>81</u>		
1. PLACE OF DEATH a. COUNTY <u>HOLT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>RURAL Bigelow Twp.</u>		c. LENGTH OF STAY (In this place) <u>15 yrs.</u>		c. CITY OR TOWN <u>Bigelow</u> <u>240</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>8 M S &amp; W of MOUND City</u>				e. STREET ADDRESS (If rural, give location) <u>8 mi S &amp; W of MOUND City</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>NELLIE</u> b. (Middle) <u>PEARL</u> c. (Last) <u>MILLER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 13, 1955</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>FEB 13, 1897</u>		
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours		IF UNDER 1 MIN. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>IN THE HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Rushville Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>NOAH H. WOOLSTON</u>			13b. MOTHER'S MAIDEN NAME <u>CAROLINE BUTCHER</u>			14. NAME OF HUSBAND OR WIFE <u>CLYDE 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>359-20-2009</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>CLYDE MILLER, Bigelow, Mo.</u>				
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) <u>Virus Pneumonia</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) <u>492X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic nephritis</u>		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 (Month) (Day) (Year) (Hour) OF INJURY		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>12-2</u> , 19 <u>55</u> , to <u>12-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-12</u> , 19 <u>55</u> and that death occurred at <u>6 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>F E Hogan Md</u>				23b. ADDRESS <u>Mound City Mo</u>		23c. DATE SIGNED <u>12-14-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12-15-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>		24d. LOCATION (City, town, or county) (State) <u>MOUND City, MO.</u>		
DATE REC'D BY LOCAL REG. <u>12-14-55</u>		REGISTRAR'S SIGNATURE <u>James H. Crawford</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Crawford</u>		ADDRESS <u>MOUND City, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *James H. Crawford*.....

Licensed Embalmer No. *4790*.....

P. O. Address *Mount...*.....

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.