

FILED JUL 3 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22473

BIRTH NO. _____		REG. DIST. NO. 224		PRIMARY REG. DIST. NO. 3072		Registrar's No. 98	
1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Saline			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. LENGTH OF STAY (In this place) 2 mos		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gilliam		0.970 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bufford Rest Home Marion Mo.				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		a. (First) William		b. (Middle)		c. (Last) Miller	
4. DATE OF DEATH		June, 21 1956		5. SEX male		6. COLOR OR RACE negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		widowed		8. DATE OF BIRTH Nov. 11th 1874		9. AGE (In years last birthday) 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY?	
retired laborer		no		Saline Co. Mo.		U.S.	
13a. FATHER'S NAME Simon Miller		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE none			
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 ADDRESS			
no		no		Lester Miller, Gilliam, Mo.			
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) Chronic myocarditis  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Chronic Prostatitis  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH Don't know	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
✓		4222				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?			
				(6-21-)			
22. I hereby certify that I attended the deceased from 6-6-1956, to 6-21-1956, that I last saw the deceased alive on 6-12-1956, and that death occurred at 6 a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Walter H. Madison, M.D.				23b. ADDRESS Marshall, Mo.		23c. DATE SIGNED 6-23-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/22/1956		24c. NAME OF CEMETERY OR CREMATORY Cambridge		24d. LOCATION (City, town, or county) (State) R.F.D. Gilliam Mo.	
DATE REC'D BY LOCAL REG. 6-25-56		REGISTRAR'S SIGNATURE Cecil G. Keah		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill Brothers, Slater, Mo.			

WRITE PLAINLY—USING UNFAADING 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 .....  
Student Embalmer,

Signed

*A. C. Hill*

Licensed Embalmer No.

*3090*

P. O. Address

*Stater, 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.