

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27539**  
174

FILED SEP 12 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **395** PRIMARY REG. DIST. NO. **3039** Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH a. COUNTY <b>LINN</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>LINN</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>MARCELINE</b>		c. LENGTH OF STAY (In this place) <b>2d</b>	c. CITY OR TOWN <b>ST CATHERINE</b>		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 <b>St. Francis Hosp.</b>			e. STREET ADDRESS (If rural, give location) <b>Rt # 1</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>CORA</b> b. (Middle) <b>EILEEN</b> c. (Last) <b>MILLER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 30 1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 19 1919</b>		9. AGE (In years last birthday) <b>37</b> IF UNDER 1 YEAR Days <b>19</b> IF UNDER 14 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City or State or Foreign Country) <b>St. Catherine, Mo. 2159.</b>		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <b>Thomas B. Bluffow</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Anderson</b>		14. NAME OF HUSBAND OR WIFE <b>Lawrence Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Laurence Miller, St. Catherine, Mo.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, athenia, etc. It means the disease, injury, or complication which caused death.</i>					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolism</b>			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) <b>Acute phlebitis</b> DUE TO (c) <b>Arteriosclerotic cerebrovascular disease</b>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4221</b>			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 <b>Aug 26</b> , 1956, to <b>Aug 30</b> , 1956, that I last saw the deceased alive on <b>Aug 29</b> , 1956, and that death occurred at <b>7:10 A.M.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>George Gary MD</b>			23b. ADDRESS <b>Marceline, Linn</b>		23c. DATE SIGNED
24a. BURIAL, CREMATION REMOVAL (Specify)	24b. DATE <b>Sept. 1, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Brookfield, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>Aug 30, 1956</b>		REGISTRAR'S SIGNATURE <b>Mary Riggway</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ed. [unclear]</b>	

(Licensed Embalmer's Statement on Reverse Side)

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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..... *E. C. Parson*

Licensed Embalmer No. *4037*

P. O. Address *4037*

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.