

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42569**

FILED NOV 19 1956

BIRTH NO. _____ REG. DIST. NO. **314** PRIMARY REG. DIST. NO. **6062** Registrar's No. **65**

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Collins Doval		c. LENGTH OF STAY (in this place) 6 years	c. CITY OR TOWN Rural-Collins
d. FULL NAME OF HOSPITAL OR INSTITUTION Doval Township		• STREET ADDRESS (If rural, give location) Doval Township 0930	

3. NAME OF DECEASED (Type or Print)	a. (First) R.	b. (Middle) Z.	c. (Last) Miller	4. DATE OF DEATH (Month) (Day) (Year)	October 24, 1956
-------------------------------------	----------------------	-----------------------	-------------------------	---------------------------------------	-------------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 22, 1894	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	--------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) Jackson County Mo;	12. CITIZEN OF WHAT COUNTRY? USA
---	---	--	---

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Deceased
-----------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW# I	16. SOCIAL SECURITY NO. 496-10-0024	17. INFORMANT'S SIGNATURE OR NAME Temple Hope, Oklahoma City, Okla	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Sudden
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suicide		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ill Health 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 _____	20. AUTOPSY? 976X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Collins; Doval, St. Clair Missouri
---	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-24-56 1:30 P.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Gun Shot wound in left Breast
---	---	---

22. I hereby certify that I attended the deceased from 10, to 19, that I last saw the deceased alive on 10-25-56, and that death occurred at 1:30 P.M. on 10-25-56, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James B. Baseline (M.D.)	23b. ADDRESS Osceola Mo	23c. DATE SIGNED 10-25-56
--	--------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/27/56	24c. NAME OF CEMETERY OR CREMATORY Osceola	24d. LOCATION (City, town, or county) (State) Osceola Missouri
---	---------------------------	---	---

DATE REC'D BY LOCAL REG. 11-1-56	REGISTRAR'S SIGNATURE Paul E. Leavers	25. FUNERAL DIRECTOR'S SIGNATURE J.B. Baseline	ADDRESS Osceola Mo
---	--	---	---------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

1000

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.B. [Signature]*.....

Licensed Embalmer No. *7038*.....

P. O. Address *Osceola*.....

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.