

FILED JAN 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3481**

BIRTH NO. _____		REG. DIST. NO. <b>360</b>		PRIMARY REG. DIST. NO. <b>3076</b>		Registrar's No. <b>6</b>	
1. PLACE OF DEATH a. COUNTY <b>Vernon</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY <b>Vernon</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Nevada</b>		c. LENGTH OF STAY (In this place) <b>37 yrs.</b>		c. CITY OR TOWN <b>Nevada</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>507 S. Cedar</b>				e. STREET ADDRESS (If rural, give location) <b>507 S. Cedar</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Edna</b>		b. (Middle) <b>Edith</b>		c. (Last) <b>Miler</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1-2-57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>wh</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Sept. 7, 1898</b>		9. AGE (In years last birthday) <b>58</b>	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) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and State or Foreign Country) <b>Litchfield, Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Henry Miler</b>			13b. MOTHER'S MAIDEN NAME <b>Rozine Walker</b>			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) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Homer Miler, 218 S. Elm, Nevada.</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <input checked="" type="checkbox"/> DUE TO (c) <input checked="" type="checkbox"/>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>				Mo. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Nevada Vernon Mo.</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>none</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I attended the deceased from <b>1-1</b> , 19 <b>57</b> , to <b>1-2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-1</b> , 19 <b>57</b> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <b>W. P. Love MD</b> (Degree or title)				23b. ADDRESS <b>Nevada Mo</b>		23c. DATE SIGNED <b>1-6-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1-5-57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Moore Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Nevada, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>1-10-1957</b>		REGISTRAR'S SIGNATURE <b>Anna S. Furry</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ferry Funeral Home, Nevada, Mo.</b>			

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 *L. Augustus Ferry*.....

Licensed Embalmer No...*476*

P. O. Address...*T. Nevada*

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.