

Health,
Welfare
Public
Service

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31396

STATE FILE NUMBER

Registration District No. 120 Primary Registration District No. 4197 Registrar's No. 117

300
-57

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| 1. PLACE OF DEATH a. COUNTY Gentry | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Gentry | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Stanberry | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Stanberry |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION North Alanthus Ave. 3 yrs | | Length of stay in lb | d. STREET ADDRESS (If outside, give location) 819 N. Alanthus Ave |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Mrs. Lula Middle Miller Last | | | 4. DATE OF DEATH Month Oct. Day 7 Year 1957 | |
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|-------------------------|----------------------------------|---|--|-------------------------|---|--------------------------------|
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 18. 1885 | 9. AGE (In years) 72 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
|-------------------------|----------------------------------|---|--|-------------------------|---|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of last 12 mo. life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Agency, Mo. | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
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| 13a. FATHER'S NAME John Barnett | 13b. MOTHER'S MAIDEN NAME Sarah Cobb | 14. NAME OF HUSBAND OR WIFE George Miller (Deceased) |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. 488-44-8177 | 17. INFORMANT Mr. Raymond Miller | Address Stanberry, Mo. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs |
| DUE TO (b) Chronic Sclerosis | | |
| DUE TO (c) Hypertension | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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|--|--|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY Hour Month, Day, Year p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|--|--|--|------------------------------|--------|-------|

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| 21. I attended the deceased from 1952 to Oct 7-1957 and last saw her alive on Oct 6-1957 Death occurred at 5:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE R. L. Milligan (Degree or title) | 22b. ADDRESS Stanberry Mo | 22c. DATE SIGNED 10-8-57 |
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| 23a. BURIAL, CREMATION, REBURY (State) | 23b. DATE 10/9/57 | 23c. NAME OF CEMETERY OR CREMATORY High Ridge | 23d. LOCATION (City, town, or county) (State) Stanberry, Gentry Mo. |
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| 24. FUNERAL DIRECTOR Phillips Mortuary, Stanberry | ADDRESS | 25. DATE RECD. BY LOCAL REG. Oct-9-1957 | 26. REGISTRAR'S SIGNATURE Mrs. L. W. Bare |
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(Licensed Embelmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DEC 11 1957
OCT 7 1957

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

Robert F. Phillips

Licensed Embalmer No. 1898

P. O. Address Stonewall

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.