

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008946
STATE FILE NUMBER 334

FILED MAR 31 1958

Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

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-57

1. PLACE OF DEATH a. COUNTY <u>Euchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Huron</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>No. Meth. Hosp</u>		Length of stay in lb <u>7 Hours</u>	d. STREET ADDRESS <u>5 N. N.S. Huron</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Kay</u> Middle <u>Anette</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24 1957</u>		9. AGE (In years - last birthday) <u>3</u> Months <u>28</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Atchison Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Norman Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Alice Clifton</u>	14. NAME OF HUSBAND OR WIFE <u>Not Married</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Norman Miller</u>	Address <u>Huron Kansas</u>
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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) <u>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Dehydration</u> DUE TO (c) <u>Malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7720</u>
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 checked="" type="checkbox"/> NO <input type="checkbox"/>

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.) <u>1</u>
20c. TIME OF INJURY Hour <u>1</u> Month <u>3</u> Day <u>22</u> Year <u>1958</u> a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <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.) <u>Burch. County St Joseph Mo</u>	20f. CITY, TOWN, OR LOCATION <u>St Joseph Mo</u>	COUNTY <u>St Joseph Mo</u>	STATE <u>Mo</u>
21. I attended the deceased from <u>3-22-58</u> to <u>3-22-58</u> and last saw ^{per} <u>him</u> alive on <u>3-22-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>H. Peterson M.D.</u>	(Degree or title)	22b. ADDRESS <u>St Joseph Mo</u>	22c. DATE SIGNED <u>3-24-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/23/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Murray Cemetery</u>	23d. LOCATION (City, town, or county) <u>Troy Kansas</u>	(State)
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24. FUNERAL DIRECTOR <u>Hermon B. Tibbitts</u>	ADDRESS <u>Troy Kansas</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 24, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Goodell</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Charles E. Bennett*

Licensed Embalmer No. *4677*

P. O. Address *St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.