

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021016

STATE FILE NUMBER

639

FILED JUN 23 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>DeKalb</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp, Life</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>L.</b> Last <b>MILLER</b>			4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1862</b>		9. AGE (In years last birthday) <b>95</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Farmer &amp; Garden</b>		11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>John Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Emelie 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 <b>Margaret B. Miller, DeKalb Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>fractured right humerus (pathological)</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5/18/58</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>probable carcinoma prostate</b>					<b>50</b> <b>5/27/58</b>
DUE TO (c) <b>177X</b>					
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"/>
20a. ACCIDENT <input checked="" 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.) <b>Pt. fell. Lost his balance while trying to open a window. Fell backwards on arm.</b>		
20c. TIME OF INJURY Hour <b>10:00</b> a.m. Month, Day, Year <b>May 16, 1958</b>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>In home</b>		20f. CITY, TOWN, OR LOCATION <b>DeKalb Buchanan Missouri</b>	
21. I attended the deceased from Death occurred at <b>8:00</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			and last saw her/him alive on <b>5/27/58</b>		
22a. SIGNATURE <b>Jacob Kulowicki MD</b>			22b. ADDRESS <b>413-16 Corby Bldg.</b>		22c. DATE SIGNED <b>6/11/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 31, 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Joseph, Missouri</b>		23e. ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>June 17, 1958</b>	
24. FUNERAL DIRECTOR <b>Shubert - Flanagan</b>			26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Kendall</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. may use only statement related. All diseases in Part I must be causally related.

JUL 23 1958

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 *Walter M. ...* .....

Licensed Embalmer No. 4244-2

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.