

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031841
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1011

S. 300
1-57

| | | | | | |
|---|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <u>Missouri</u> b. COUNTY <u>Buchanan</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>St. Joseph</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>I703 So. 26th</u> | | Length of stay in 1b <u>Life</u> | d. STREET ADDRESS (If outside, give location) <u>I703 So. 26th</u> | | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Lucas</u> Middle <u>Paul</u> Last <u>Miller</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 18, 1877</u> | 9. AGE (In years last birthday) <u>80</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during rest of working life, even if retired) <u>Ret. (12) Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CB&Q Railroad</u> | 11. BIRTHPLACE (City and state or country) <u>St. Joseph, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>John Miller</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Ann O'Rourke</u> | | 14. NAME OF HUSBAND OR WIFE <u>Cora Belle</u> | |
| 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>707-05-8364</u> | 17. INFORMANT Address <u>Mrs. Charles H. Henderson, St. Joseph, Mo.</u> | | |
| 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>RENAL INSUFFICIENCY</u> DUE TO (b) <u>CARCINOMA BLADDER</u> DUE TO (c) <u>1810</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>2 yr.</u> |
| 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.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u> | | | | | |
| 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 | |
| 21. I attended the deceased from <u>7-19-56</u> to <u>9-19-58</u> and last saw her alive on <u>9-15-58</u> Death occurred at <u>4:55</u> A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Robert B. Gristow M.D.</u> | | | 22b. ADDRESS <u>706 7th St Joe Mo.</u> | | 22c. DATE SIGNED <u>9-19-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Sept. 22, 58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Herman Wm Lidenfader St Joseph Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>Sept 21, 1958</u> | | 26. REGISTRAR'S SIGNATURE <u>Wm. Clark Stoddell</u> | |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.
 Dr. Robert B. Gristow
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

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 L. Gagle*

Licensed Embalmer No. 3308.....

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.