

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035177

STATE FILE NUMBER

FILED SEP 24 1958 Registration District No. 323 Primary Registration District No. 4480 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY Schuyler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Schuyler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greentop		c. CITY OR TOWN Greentop	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION at family home		d. STREET ADDRESS (If outside, give location) R. F. D.	
3. NAME OF DECEASED (Type or print) First Daniel Middle Henry Last Miller		4. DATE OF DEATH Month Sept Day 4, Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11b. KIND OF BUSINESS OR INDUSTRY Farm	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Casper Miller		13b. MOTHER'S MAIDEN NAME Adaline Wolf	14. NAME OF HUSBAND OR WIFE Anna P. Ladwig Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) No		16. SOCIAL SECURITY NO. 498-40-2187	17. INFORMANT Mrs. Anna P. Miller, Greentop, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive Cardiac Failure DUE TO (b) Myocardial Failure DUE TO (c) Mitral Stenosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years 20 years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 Month, Day, Year 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.) 8/23/58		20f. CITY, TOWN, OR LOCATION COUNTY STATE 9/4/58 Greentop Mo	
21. I attended the deceased from Death occurred at 9:25 P.M. to 9/4/58 and last saw him alive on 9/4/58 in on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or other person) Edward M. Roberts, M.D.		22b. ADDRESS Queen City, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/6/58	23c. NAME OF CEMETERY OR CREMATORY Greentop Cemetery
23d. LOCATION (City, town, or county) (State) Greentop, Mo.		23e. DATE SIGNED 9/5/58	
24. FUNERAL DIRECTOR Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. Sep. 10-58	
26. REGISTRAR'S SIGNATURE Pess R. Drake			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *George W. Savall*

Licensed Embalmer No. *4799*
P. O. Address *Windsor, N.C.*

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.