

t. Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036079

STATE FILE NUMBER

FILED OCT 20 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 976

S. 300
V. 1-57

3

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hosp. D.O.C.		Length of stay in 1b 10 days		d. STREET ADDRESS (If outside, give location) 039 E. 1023 W. Kerr		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Jacob Middle Herschel Last Miller				4. DATE OF DEATH Month Oct. Day 11 Year 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1901		9. AGE (In years, last birthday) 57	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Shop		11. BIRTHPLACE (City and state or country) Nionqua, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13a. FATHER'S NAME Thomas C. Miller			13b. MOTHER'S MAIDEN NAME Hulda Garner			14. NAME OF HUSBAND OR WIFE Lorene Miller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y, N, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 499-09-7288		17. INFORMANT Address Lorene Miller, Springfield, 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) Probable Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH Unknown		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____								
DUE TO (c) UNATTENDED BY A PHYSICIAN						4201		
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 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 _____ 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at 9:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22. SIGNATURE (Degree or title) James R. Amos, M.D.				22a. ADDRESS Greene County Health Officer 5 Springfield, Missouri			22c. DATE SIGNED 10-16-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		23b. DATE 10-15-1958	23c. NAME OF CEMETERY OR CREMATORY Cohening Crematory		23d. LOCATION (City, town, or county) (State) Webster County, Missouri			
24. FUNERAL DIRECTOR ADDRESS Rex Rainey - Springfield, Mo.				25. DATE RECD. BY LOCAL REG. 10-16-58		26. REGISTRAR'S SIGNATURE Effie G. Melton		

3-11-78 MD

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 *[Handwritten Signature]* Licensed Embalmer No. 3317

P. O. Address

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.