

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045252  
STATE FILE NUMBER

FILED JAN 5 1959

Registration District No. 299 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Reynolds</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Reynolds</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lesterville</b>		c. CITY OR TOWN <b>Lesterville</b> <sup>0900</sup>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> #		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> #	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1 mi. North of Lesterville</b>		d. STREET ADDRESS (If outside, give location) <b>1 mi. N of Lesterville</b>	
Length of stay in lb <b>life</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES CLARENCE MILLER</b>			4. DATE OF DEATH Month Day Year <b>Dec. 23 - 1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4 1894</b>
9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days <b>5 19</b>	IF UNDER 24 HRS. Hours Min. <b>0 0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>barber</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lesterville Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>James Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Barnes</b>	14. NAME OF HUSBAND OR WIFE <b>Ruth Bryant Miller</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes WW I</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Ruth Miller, Lesterville 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>Arctic Resuscitation</b> <b>Hypertension</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4211</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs. unknown</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 _____ to _____ and last saw her alive on _____ Death occurred at <b>9.00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>B. M. Fitzpatrick M.D.</b>		22b. ADDRESS <b>Lesterville Mo</b>	22c. DATE SIGNED <b>12/29/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>12-26-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lesterville Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>White Funeral Home, Ironton Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12/29/58</b>	26. REGISTRAR'S SIGNATURE <b>B. M. Fitzpatrick</b>

(Licensed Embalmer's Statement on Reverse Side)

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

MAN 7 1958

MAN 8 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 *Arnell White* .....

Licensed Embalmer No. *3212* .....

P. O. Address *Imitor* .....

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.