

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002166
STATE FILE NUMBER

FILED JAN 15 1959

Registration District No. 217 Primary Registration District No. 5785 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Long Prairie Twship</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Rt # 1 Bertrand</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in lb <u>10 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>3 1/2 Miles West of Charleston</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>XXXX</u> Middle <u>Mattie</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>3,</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 9, 1896</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>	
13a. FATHER'S NAME <u>John Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Cora Miller ?</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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. - - - - -		17. INFORMANT Address <u>John Roy Williams Rt # 1 Bertrand, M</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>Burned to death</u>					INTERVAL BETWEEN ONSET AND DEATH
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) <u>9/160</u>					
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.) <u>Mrs. Miller was burned to death when she was trapped in her home - body was charred</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>10:30 P.M. Jan. 3, 1959</u>			20f. CITY, TOWN, OR LOCATION COUNTY <u>667</u> STATE _____		
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 <u>After death as Coroner</u> and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>[Signature] Coroner</u>			22b. ADDRESS <u>Charleston, Mo.</u>		22c. DATE SIGNED <u>1/4/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/4/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>
24. FUNERAL DIRECTOR <u>Mc Mikle Charleston, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1-9-59</u>		26. REGISTRAR'S SIGNATURE <u>Dorothy B. Hathorn</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

RECEIVED
Miss. Co. Health Dept
County File No. _____
Date Filed 1-13-59

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. 4895
P. O. Address [Handwritten 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.