

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013792  
STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 74

300  
1-57

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		c. CITY OR TOWN Carthage 0493	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1823 Forest		d. STREET ADDRESS (If outside, give location) 1823 Forest St	
Length of stay in lb 4 yrs		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD BRATON MILLER			4. DATE OF DEATH Month Day Year April 7, 1959		
--	--	--	---	--	--

5. SEX male G	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 Dec 3, 1889	9. AGE (In years last birthday) 69	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days	12. Hours	13. Min.
---------------	------------------------	---	------------------------------	------------------------------------	-------------------------	------------------------	-----------	----------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. policeman	10b. KIND OF BUSINESS OR INDUSTRY law enforcement	11. BIRTHPLACE (City and state or country) Roodhouse, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	----------------------------------

13a. FATHER'S NAME Rufus Miller	13b. MOTHER'S MAIDEN NAME Ida Jones	14. NAME OF HUSBAND OR WIFE Eula Ford Miller
---------------------------------	-------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW I	16. SOCIAL SECURITY NO. 496-10-4104	17. INFORMANT Eula Miller, 1823 Forest, Carthage, Mo	Address
--	-------------------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumed natural causes		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) (Patient complained of pains in chest. Doctor was called but patient died before doctor's arrival. No previous attending physician.)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (e.g., terminal disease condition given in PART I (a)) 4202		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 Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION COUNTY 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 did not attend to 4-7-59 and last saw her alive on  
Death occurred at 3:15 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Local Registrar E. M. Clinton	22b. ADDRESS Carthage, Mo	22c. DATE SIGNED 4-7-59
--	---------------------------	-------------------------

23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE 4-9-59	23c. NAME OF CEMETERY OR CREMATORY Sarcxie Cemetery	23d. LOCATION (City, town, or county) (State) Sarcxie, Mo
--	------------------	---	---

24. FUNERAL DIRECTOR Knell Mortuary, Carthage, Mo	25. DATE RECD. BY LOCAL REG. 4-7-59	26. REGISTRAR'S SIGNATURE E M Clinton
---	-------------------------------------	---------------------------------------

(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

137

APR 20 1959

1959

APR 20 1959

JAN 14 1960

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 *Frank W. Knull* .....

Licensed Embalmer No. 4440 .....

P. O. Address Carthage, 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.