

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016606
STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 159

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirksville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>K.O.H.</u>		Length of stay in ^{1b} <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>509 W. Gardner</u>
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Edward</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1878</u>
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper & Delivery man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Market</u>	11. BIRTHPLACE (City and state or country) <u>Nebraska City, Neb</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>John Miller</u>	
13b. MOTHER'S MAIDEN NAME <u>Kate Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>Hattie Rale Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war & dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-10-6861-A</u>	
17. INFORMANT <u>Mr. Hattie Miller</u>		Address <u>Kirksville, Mo.</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>Medullary Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Uremia</u>			<u>1 week</u>
DUE TO (c) <u>Arteriosclerotic Nephrosclerosis</u>			<u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General Debility</u>			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 <u> </u> a.m. <u> </u> p.m. <u> </u>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20e. CITY, TOWN, OR LOCATION <u>Kirksville</u>		COUNTY <u>Mo.</u>	STATE
21. I attended the deceased from <u>4/22/59</u> to <u>5/20/59</u> and last saw <u>him</u> alive on <u>5/20/59</u> Death occurred at <u>9:55 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. D. Bestmann, D.O.</u>		(Degree or title) <u>D.O.</u>	22b. ADDRESS <u>Kirksville, Mo.</u>
22c. DATE SIGNED <u>5/20/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5/23/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City, town, or county) <u>Macon, Macon, Mo.</u>
24. GENERAL DIRECTOR <u>Novak Foster, Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-22-59</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Patliff</u>

Health, & Welfare Public Service

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part II must be causally related.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

E. D. BESTMANN, D.O.

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 *Novak Foster*
Licensed Embalmer No. *49742*
P. O. Address *Ferksville, Mo*

3. 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.