

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020056
STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 92

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Saline</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marshall RFD# 4</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>Fitzgibbon Hosp</u>		Length of stay in lb <u>18 days</u>	d. STREET ADDRESS (If outside, give location) <u>4 Mi. NE Marshall</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Frances</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1880</u>	9. AGE (In years last birthday) <u>78</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>	
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>None</u>	11. BIRTHPLACE (City and state or country) <u>Saline County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Jacob Clauson</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Wyan</u>		14. NAME OF HUSBAND OR WIFE <u>Carlton W. Miller</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. <u>none</u>	17. INFORMANT Address <u>Shearman Miller R#4 Marshall 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>Heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Fractured hip & phis</u> DUE TO (c) <u>9040</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>21</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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>Fell in bathroom at home</u>			
20c. TIME OF INJURY Hour <u>8</u> AM <u>PM</u> Month <u>May</u> Day <u>1959</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Marshall</u>		COUNTY <u>Saline</u>	STATE <u>Mo</u>
21. I attended the deceased from <u>May 21</u> to <u>June 7</u> and last saw her alive on <u>June 7-1959</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Arthur J. Hayes MD</u> (Degree or title)			22b. ADDRESS <u>Marshall Mo</u>		22c. DATE SIGNED <u>6/8/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park</u>		23d. LOCATION (City, town, or county) (State) <u>Marshall Mo</u>
24. FUNERAL DIRECTOR <u>Haines Funeral Home</u>		ADDRESS <u>Slater, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-9-'59</u>	26. REGISTRAR'S SIGNATURE <u>Cecil G. Read</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Walter J. Aime, Jr.*

Licensed Embalmer No. *4557*

P. O. Address *Shelton, M*

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.