

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022306

FILED JUL 13 1959 251

167

STATE FILE NUMBER.

Registration District No. _____ Primary Registration District No. ~~2448~~ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Nodaway				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural: Polk Twp.		Length of stay in lb 2 months		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home.			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3021 Jule		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ELTA Middle ESTELLA Last MILLER				4. DATE OF DEATH Month July Day 5 Year 1959					
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/16/1888	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Avenue City, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Albert S. Miller			13b. MOTHER'S MAIDEN NAME Augusta Gmuschke			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Carl Miller, 2505 Lucille, St. Joseph, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach							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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ a.m. _____ p.m. Month, Day, Year _____									
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/him alive on _____ Death occurred at 12:05p. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE B. F. Gyleud M.D. (Degree or title)				22b. ADDRESS Marionville Mo				22c. DATE SIGNED 7/7/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 7/7/1959	23c. NAME OF CEMETERY OR CREMATORY Long Branch Cemetery			23d. LOCATION (City, town, or county) Andrew County Mo.			
24. FUNERAL DIRECTOR Hector Bowman, ADDRESS St. Joseph, Mo.			25. DATE RECD. BY LOCAL REG. 7-7-59		26. REGISTRAR'S SIGNATURE Kess Holt				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 24 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

William J. Gilling

Licensed Embalmer No. 4535

P. O. Address St. Joseph, Pa.

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.