

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS AUG 1 0 1959

59-024909

Registration District No. 137 Primary Registration District No. _____ Registrar's No. 186 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Windsor</u>		Length of stay in 1b <u>8 yrs.</u>		c. CITY OR TOWN <u>Windsor</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>Windsor Hospital</u>				d. STREET ADDRESS (If outside, give location) <u>307 W Center</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>COBA</u> Middle <u>GERTRUDE</u> Last <u>MILLER</u>			4. DATE OF DEATH Month <u>July</u> Day <u>17</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"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 14-1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR 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		11. BIRTHPLACE (City and state or country) <u>Benton County Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>H.W. Winn</u>		13b. MOTHER'S MAIDEN NAME <u>Celeste Ellis</u>		14. NAME OF HUSBAND OR WIFE <u>Jimie Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Ray Miller Windsor 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>Circulatory Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Wide spread Metastasis</u> <u>unknown</u> DUE TO (c) <u>Carcinoma of stomach (Primary)</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>Lower Nephrou Nephrosis due to circulatory failure</u> 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 checked="" type="checkbox"/> NO <input 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 <u>1st Part of July 59, to 17 July 59</u> and last saw her/him alive on <u>17 July 59</u> Death occurred at <u>12:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>London W. Ruffel MD</u>				22b. ADDRESS <u>114 N. Main Windsor Mo</u>		22c. DATE SIGNED <u>17 July 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 19, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clinton Mo</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Ellis M. Houston Windsor Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-30-59</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Wm L. Downing

Licensed Embalmer No. 5067

P. O. Address Windsor

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.