

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025874

FILED JUL 16 1959

187

Primary Registration District No. 3040

Registrar's No. 1712

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe		Length of stay in 1b 4 years	c. CITY OR TOWN Chillicothe Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Susans Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Susans Nursing Home Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LILLIE Middle MILLER Last MILLER			4. DATE OF DEATH Month July Day 6 Year 1959			
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/27/1876	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY DeWitt Co. Ill.	11. BIRTHPLACE (City and state or country) u.s.a.	12. CITIZEN OF WHAT COUNTRY u.s.a.
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13a. FATHER'S NAME Micheal Troutman	13b. MOTHER'S MAIDEN NAME Louisa geigler	14. NAME OF HUSBAND OR WIFE Claud Miller
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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 Klank Miller, Norborne, Mo.	Address
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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>MYOCARDIAL FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>DIABETIC ACIDOSIS</u>		<u>96 hrs.</u>
	DUE TO (c) <u>Adeno-CA. Descending Colon</u>		<u>5 yrs.</u>

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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from 7-31-55 to 7-6-59 and last saw her/him alive on 7-6-59
Death occurred at 12:25 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. W. Matheny M.D.</u>	22b. ADDRESS <u>Chillicothe, Mo.</u>	22c. DATE SIGNED <u>7-7-59.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/8/1959	23c. NAME OF CEMETERY OR CREMATORY Fairhaven Cemetery	23d. LOCATION (City, town, or county) (State) Norborne Mo.
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24. FUNERAL DIRECTOR B.W. Gibson	ADDRESS carrollton, Mo.	25. DATE RECD. BY LOCAL REG. 7/7/59	26. REGISTRAR'S SIGNATURE Franco B Nell
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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

Ben W. Gibson

Licensed Embalmer No.

2961

P. O. Address

Parroll

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.