

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029210

FILED VS SEP 4 1959

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4027

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cass			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 7 days		c. CITY OR TOWN Harrisonville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lakeside Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 302 E. Chestnut			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Veria Lugene Miller				4. DATE OF DEATH Month Day Year August 18, 1959			
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-17-1898	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Perry, Illinois		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Ira New			13b. MOTHER'S MAIDEN NAME Clara Hathaway			14. NAME OF HUSBAND OR WIFE Roye Miller	
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. yes -		17. INFORMANT Address Harrisonville, Mo Roye Miller 302 E. Chestnut			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 12 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) hysterectomy for carcinoma of cervix atrim 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 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 Aug 12 1959 to Aug 18 1959 and last saw her alive on Aug 17 1959 Death occurred at Lakeside Hosp. 3550 on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (In full or title) C. Lovlovich MD				22b. ADDRESS 25 E. 12th. K. C. Mo		22c. DATE SIGNED 8-18-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 8-21-59	23c. NAME OF CEMETERY OR CREMATORY Sharon Cem.		23d. LOCATION (City, town, or county) (State) Drexel, Cass Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS Runyan Funeral Home Drexel, Mo.				25. DATE RECD. BY LOCAL REG. 8-19-59	26. REGISTRAR'S SIGNATURE neva Marshall		

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION
C. A. LOVLOVICH D. O.

MAR 1 1960

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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