

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031189

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Registration District No. _____ Primary Registration District No. 3074 Registrar's No. 155

STATE FILE NUMBER

FILED

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTON</u>		Length of stay in 1b <u>FEW MIN.</u>	c. CITY OR TOWN <u>MORLEY</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>Mo. Delta Comm. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>P.O. Box 87</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JERIMIAH MATTHEW (MATT) MILLS</u>			4. DATE OF DEATH Month Day Year <u>AUGUST 22, 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>28</u>	IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	11. BIRTHPLACE (City and state or country) <u>BAXTER, TENN.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Mills</u>	13b. MOTHER'S MAIDEN NAME <u>REBECCA</u>	14. NAME OF HUSBAND OR WIFE <u>MARY ELIZABETH RUGH</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>417-14-0668</u>	17. INFORMANT <u>MARY P. MILLS MORLEY, Mo.</u>
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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>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>—</u>		
DUE TO (c) <u>—</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>—</u>		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 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			
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 D. O. A. to _____ and last saw her/him alive on _____
Death occurred at 5:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>E. D. Urban, M.D.</u>	22b. ADDRESS <u>Sikeston</u>	22c. DATE SIGNED <u>8-29-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-24-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MATTHEWS CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MATTHEWS, Mo.</u>
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24. FUNERAL DIRECTOR <u>W. B. Nunnelee</u> ADDRESS <u>NUNNELEE FUN. CHAPEL, SIKESTON, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Miss Ellen Hunter</u>
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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 Edward E. Pinnick

Licensed Embalmer No. 4164

P. O. Address Sikeston, Mo.

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.