

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039033

FILED VS NOV 30 1959

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

ENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Buchanan</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Joseph</b>	a. STATE <b>Missouri</b>	b. COUNTY <b>Buchanan</b>
Length of stay in 1b <b>Most of Life</b>		c. CITY OR TOWN <b>St. Joseph</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) <b>MO. Meth. Hospital</b>		d. STREET ADDRESS <b>904 S. 26th St.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>Ida</b>	Middle <b>B.</b>	Last <b>Miller</b>	4. DATE OF DEATH	Month <b>November</b>	Day <b>20</b>	Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1880</b>	9. AGE (last birthday) <b>79</b>	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>William Hennemann</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Wilhelminia Helsel</b>	14. NAME OF HUSBAND OR WIFE <b>Frank A. Miller</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Frank A. Miller</b>	Address <b>St. Joseph, Mo.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Hypertatic Pneumonia</b>	<b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Ca of Bladder</b>	<b>unknown</b>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)	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
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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 _____ s.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 **Jan. 19 - 1956** to **Nov. 20 - 1959** and last saw her alive on **Nov. 20 - 1959**  
Death occurred at **5:30 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Albert H. Muench M.D.</b>	(Degree or title)	22b. ADDRESS <b>St. Joseph, Mo.</b>	22c. DATE SIGNED <b>Nov. 23 - 1959</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/24/59.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Joseph, Missouri.</b>
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24. FUNERAL DIRECTOR <b>Mrs. Clara Goodell</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Nov. 25, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clara Goodell</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

A.H. Muench, M.D. MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Albert C. Harrington

Licensed Embalmer No. 3258

P. O. Address A. Joseph

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.