

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-041338

STATE FILE NUMBER

Registration District No. 292 Primary Registration District No. 292 Registrar's No. 27

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

3. NAME OF DECEASED (Type or print) First JOSEPH Middle HOLLIS Last MILLER			4. DATE OF DEATH Nov-6-1959 Month Nov Day 6 Year 1959	
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5. SEX MALE	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 8-21-1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HR Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) AUDRAIN COUNTY, MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME WINSTON D. MILLER	13b. MOTHER'S MAIDEN NAME LAURA BELIE BERRY	14. NAME OF HUSBAND OR WIFE LEILA J. 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)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs Leola J Miller Monroeville Mo</i> Address R2
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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) CORNARY OCCULSION		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	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
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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 10:25 a.m. Month, Day, Year Nov 6 1959
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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 STOUTSVILLE, MO	COUNTY STOUTSVILLE STATE MO
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21. I attended the deceased from *no medical attention* and last saw her/him alive on *1025 A.M.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Clyde W. Wemyer Coroner</i>	22b. ADDRESS <i>Stoutsville, Mo. Rall Co.</i>	22c. DATE SIGNED 11/6/59
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23a. BURIAL, CREMATION, REMOVE (Specify) BURIAL	23b. DATE 11-8-59	23c. NAME OF CEMETERY OR CREMATORY STOUTSVILLE CEMETERY	23d. LOCATION (City, town, or county) (State) STOUTSVILLE, MO
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24. FUNERAL DIRECTOR <i>Wilson & Sons Monroeville Mo</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. 11/8/1959	26. REGISTRAR'S SIGNATURE <i>Clyde W. Wemyer</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WEST VIRGINIA STATE

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 me, Student Embalmer No. _____, working under my personal supervision.

Student _____ Signed Leslie R. Wilson
Signature of Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

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.