

MURI DIVISION-OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 4 1960 042

1000

1291

'59 043412
STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY BUCHANAN			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ANDREW			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH		Length of stay in 1b 4 months	c. CITY OR TOWN BOLCKOW		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Georgetown Nursing Home INSTITUTION 1804 Paragon			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ELVINA MILLER			4. DATE OF DEATH Month Day Year December 22, 1959			
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 March 5-77 88	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY mercer como	11. BIRTHPLACE (City and state or country) USA.	12. CITIZEN OF WHAT COUNTRY USA.		
13a. FATHER'S NAME James Johnson		13b. MOTHER'S MAIDEN NAME Louisa Prichard		14. NAME OF HUSBAND OR WIFE Samuel S 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. ---	17. INFORMANT Address Mrs. Nettie Allen Bolckow mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Generalized Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Senile psychosis				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		
19. WAS AUTOPSY PERFORMED? YES <input 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.	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 10-15-58 to 8-12-59 and last saw her ^{her} _{him} alive on 8-12-59 Death occurred at 1:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE W. C. Baker, M.D. (Degree or title)		22b. ADDRESS Savannah, Mo		22c. DATE SIGNED 12-22-59 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-22-59	23c. NAME OF CEMETERY OR CREMATORY Bolckow Cemetery	23d. LOCATION (City, town, or county) Bolckow, Missouri			
24. FUNERAL DIRECTOR BREIT & HAWKINS ADDRESS		25. DATE RECD. BY LOCAL REG. Dec. 28, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

W.C. Baker, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 7

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 James H. Haverstick

Licensed Embalmer No. 4536

P. O. Address Savannah

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.