

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000627

FILED VS FEB 1 1960 55 Primary Registration District No. 4080 Registrar's No. 10

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carroll</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Norborne</u>		Length of stay in lb <u>34 yrs</u>		c. CITY OR TOWN <u>Norborne</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>102 Eastwood</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>102 Eastwood</u>		
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Cliffard</u> Last <u>Miles</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>1960</u>						
5. SEX <u>fe</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>9-6-1874</u>	9. AGE (last birthday) <u>85</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Shelbina Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		
13a. FATHER'S NAME <u>William S Parker</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Robbins</u>		14. NAME OF HUSBAND OR WIFE <u>Roy Miles</u>				
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>None</u>		17. INFORMANT <u>Leo Miles Stat, Mo</u>				
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>Pulmonary Congestion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchitis - Sinusitis Early pneumonia 3 weeks.</u>								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>old Age -</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.)				
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 <u>1-20-60</u> to <u>1-26-60</u> and last saw <u>her</u> alive on <u>1-22-60</u>				Death occurred at <u>6:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>Frank R. Vinson MD.</u>				22b. ADDRESS <u>Carrollton Mo -</u>		22c. DATE SIGNED <u>1-26-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-28-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairhaven Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Norborne Mo.</u>		
24. FUNERAL DIRECTOR <u>Gibson Funeral Home</u>			ADDRESS <u>Norborne Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-27-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Herbert Calvert</u>	

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.