

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010596

FILED VS APR 11 1960 / 28

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 378 A STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield,		Length of stay in 1b 35 years		c. CITY OR TOWN Springfield,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA St. John's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 801 W. Walnut			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SHERMAN W. MILLER				4. DATE OF DEATH Month Day Year March 30, 1960			
5. SEX Male	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 August 29, 1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months 7 Days 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (City and state or country) Seymour, Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME William Miller			13b. MOTHER'S MAIDEN NAME Polly McPherson			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. War I			16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Martha I. Shaner Springfield, 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) INFARCTION OF MYOCARDIUM DUE TO Atherosclerotic coronary DUE TO (b) THROMBOSIS DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
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	
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 11/8/55 to 3/6/57 and last saw ^{her} _{him} live on _____ Death occurred at 10:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Glenn T. Over, M.D.				22b. ADDRESS Springfield, Mo			22c. DATE SIGNED 4/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 4, 1960	23c. NAME OF CEMETERY OR CREMATORY National		23d. LOCATION (City, town, or county) Springfield, Missouri			(State)
24. FUNERAL DIRECTOR ADDRESS Gorman-Scharpf Funeral Home Springfield, Missouri			25. DATE RECD. BY LOCAL REG. 4-7-60		26. REGISTRAR'S SIGNATURE Effie B. Melton		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 1 1961

APR 20 1961

STATEMENT BY LICENSED EMBALMER

APR 21 1961

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 L. Doolin Gorman

Licensed Embalmer No: 3177

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.