

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016172

FILED VS. MAY 16 1960

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 4320 Registrar's No. 31

UNRECORDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Marion	a. STATE Missouri b. COUNTY Marion		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Palmyra	Length of stay in 1b lifetime	c. CITY OR TOWN Palmyra	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 218½ South Main	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 218½ South Main	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Carroll	Middle Gene	Last Miller	4. DATE OF DEATH	Month May	Day 8	Year 1960
-----------------------------------------------	-------------------------	-----------------------	-----------------------	-------------------------	---------------------	-----------------	---------------------

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1959	9. AGE (last birthday) 0	IF UNDER 1 YEAR Months 4 Days 13	IF UNDER 24 HR Hours 13 Min.
------------------------------	-----------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------	-------------------------------------------	----------------------------------------------------------	-----------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Hannibal, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.
----------------------------------------------------------------------------------------------------	------------------------------------------	--------------------------------------------------------------------------------	---------------------------------------------------

13a. FATHER'S NAME Daniel D. Miller	13b. MOTHER'S MAIDEN NAME Joyce E. Fenton	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)	16. SOCIAL SECURITY NO. -----	17. INFORMANT Address Mrs. Daniel Fenton Palmyra, 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) Hydrocephalus	INTERVAL BETWEEN ONSET AND DEATH 4 mos 10 days
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
------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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. 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 Birth to may 7, 1960 and last saw ^{HER}him alive on may 7, 1960
Death occurred at 12:30 A.M. D.S.T. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Lowell W. Slocum M.D.</i> (Degree or title)	22b. ADDRESS <i>Palmyra, Mo</i>	22c. DATE SIGNED <i>5-10-60</i>
-------------------------------------------------------------------------	-------------------------------------------	-------------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/9/1960	23c. NAME OF CEMETERY OR CREMATORY Mennonite Cemetery	23d. LOCATION (City, town, or county) (State) R.F.D. Philadelphia, Mo
-------------------------------------------------------------------	-------------------------------------	------------------------------------------------------------------------	----------------------------------------------------------------------------------------

24. FUNERAL DIRECTOR Harold Garner Monroe City, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 5-12-60	26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Luke</i> <i>By Viola Freen Deputy</i>
----------------------------------------------------------------------	---------	-------------------------------------------------------	-------------------------------------------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

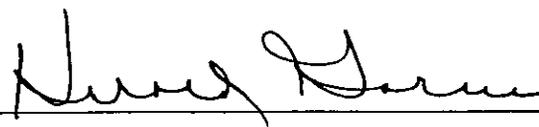
STATEMENT BY LICENSED EMBALMER

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 _____



Licensed Embalmer No. 3720

P. O. Address Monroe City, Mo.

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.