

# I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022959

FILED VS. JUN 27 1960 / 33

Registration District No. \_\_\_\_\_ Primary Registration District No. 3022 Registrar's No. 79 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARRISON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BETHANY</u> Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>NOLL HASPT</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>DAVIESS</u> c. CITY OR TOWN <u>WINSTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS _____ (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CLARENCE HOWARD MILLER</u> 4. DATE OF DEATH <u>JUNE 17 1960</u> (Month Day Year)							
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-1920</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u>	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>PATTONSBURG MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ELI MILLER</u>		13b. MOTHER'S MAIDEN NAME <u>LOWREY</u>		14. NAME OF HUSBAND OR WIFE <u><del>Esther Miller</del></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>496-24-6602</u>		17. INFORMANT <u>Eli Miller Winston MO</u> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LT. ARTERIOLAR NEPHROSCLEROSIS</u> DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u>RT. PYELONEPHRITIS PRIOR TO NEPHRECTOMY</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>25-30yrs.</u> <u>30yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Coronary Insufficiency.</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>5-18-60</u> to <u>6-17-60</u> and last saw <sup>her</sup> him alive on <u>6-17-60</u> Death occurred at <u>7:35</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Albert D. Dillie M.D.</u> (Degree or title)			22b. ADDRESS <u>Bethany, MO.</u>		22c. DATE SIGNED <u>6-18-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>6-20-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WINSTON</u>		23d. LOCATION (City, town, or county) (State) <u>WINSTON MO</u>		
24. FUNERAL DIRECTOR <u>Walter J. O'Connell, Winston</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>6-20-1960</u>		26. REGISTRAR'S SIGNATURE <u>Gella Moxey</u>		

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  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Virgil R. Howard

Licensed Embalmer No. 4077

P. O. Address Winston

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.