

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029830

FILED VS. SEP 14 1960 389

Primary Registration District No. 5173 Registrar's No. 13

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Summit Twp.</b>			Length of stay in 1b <b>D.K</b>		c. CITY OR TOWN <b>Holts Summit</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Summit Trailer Ct.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Summit Trailer Ct #46</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Betty</b> Middle <b>June</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/1930</b>	9. AGE (last birthday) <b>29</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Calhoun, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13a. FATHER'S NAME <b>Don Hudson</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Frances Masten</b>			14. NAME OF HUSBAND OR WIFE <b>George Junior Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Don Hudson</b> Address <b>Calhoun, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Focal Fibrosis-- Incardic conduction system</b>							
DUE TO (c) <b>unknown</b>							
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"/> N. <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____ to _____ and last saw her/him alive on _____. Death occurred at <b>About 9:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Herzil C. Browning, coroner</b>				22b. ADDRESS <b>Fulton, Mo.</b>			22c. DATE SIGNED <b>9-3-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug, 23, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calhoun Cemetery</b>		23d. LOCATION (City, town, or county) <b>Calhoun Mo</b>		(State)	
24. FUNERAL DIRECTOR <b>Wallace Funeral Home, Fulton, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>Sept 6 - 1960</b>		26. REGISTRAR'S SIGNATURE <b>LeRoy Claypool</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0981 I AON

VS OCT 7 1960

**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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address Fullon, N

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.