

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 7 1960

-60-031152

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 128

ENDED

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in 1b <u>3 wks</u>	c. CITY OR TOWN <u>Lebanon</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>Wallace Hospital</u>		-Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Brice St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Frances</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>9-1-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Pulaski County</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Nade Light</u>		13b. MOTHER'S MAIDEN NAME <u>Telia Cotton</u>		14. NAME OF HUSBAND OR WIFE <u>Geo. H. Miller</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>G.H. Miller-Brice St. Lebanon, Mo.</u> Address		

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>myocardial insufficiency</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>
DUE TO (b) <u>diabetes</u>	<u>2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) fractured left hip July 13, 1960.

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>slipped on wet floor and fell.</u>
20c. TIME OF INJURY <u>8 a.m. July 13, 60</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>Lebanon</u> COUNTY <u>Laclede</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>July 13, 1960</u> , to <u>Aug 25, 1960</u> and last saw her alive on <u>Aug 25, 1960</u> Death occurred at <u>10.15 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>James L. Hope, M.D.</u>	22b. ADDRESS <u>Lebanon, Mo</u>	22c. DATE SIGNED <u>8/26/60.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-27-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nt. Rose Memorial Park</u>
23d. LOCATION (City, town, or county) <u>Lebanon</u>		(State) <u>Mo.</u>

24. FUNERAL DIRECTOR ADDRESS <u>S. P. Palmey Lebanon Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-27-1960</u>	26. REGISTRAR'S SIGNATURE <u>Helle L. May</u>
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(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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed S. R. Palmer

Licensed Embalmer No. 2208

P. O. Address Lebanon

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.