

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-039162

FILED VS OCT 24 1960

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 240

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>NODAWAY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARYVILLE</u>		Length of stay in 1b <u>7 days</u>		c. CITY OR TOWN <u>Burlington Junction</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Francis Hospital</u>				d. STREET ADDRESS (If outside, give location) <u>RFD No 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>S(Initial) Miller</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>October</u> Day <u>18</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>1/31/1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Tarkio (Rural) Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>
13a. FATHER'S NAME <u>W.J. Johnson</u>			13b. MOTHER'S MAIDEN NAME <u>Christine Currie</u>		14. NAME OF HUSBAND OR WIFE <u>Clyde 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>Clyde Miller Burlington Jct 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>Cerebrovascular thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebrovascular disease</u> 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						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
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 checked="" 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>Oct. 11, 1960</u> to <u>Oct. 18, 1960</u> and last saw her alive on <u>Oct. 18, 1960</u> Death occurred at <u>7:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Maryville Mo</u>		22c. DATE SIGNED <u>10/21/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 21, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ohio Cemetery</u>		23d. LOCATION (City, town, or county) <u>Burlington Jct Mo</u>			
24. FUNERAL DIRECTOR <u>J.R. Hann</u> ADDRESS <u>Burlington Jct Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10-21-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

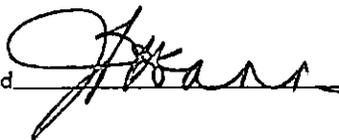
MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 2968

P. O. Address Burd. Jct

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.