

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS NOV 21 1960

-60-041306

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 104

STATE FILE NUMBER

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

3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>Gertrude</u> Last <u>MILLER</u>	4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>60</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 16, 1878</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>Carroll, Bogard, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>William Henderson</u>	13b. MOTHER'S MAIDEN NAME <u>Amanda Miles</u>	14. NAME OF HUSBAND OR WIFE <u>James T. Miller</u>
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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>489-44-0963</u>	17. INFORMANT <u>MISS PAULINE SMITH, Bogard, Mo</u>
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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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Diabetes Insipidus Mellitus</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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from Oct. 10, 1960 to Nov. 12, 1960 and last saw her alive on Nov. 12, 1960
 Death occurred at _____ P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John H. Peat</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>Carrollton, Mo</u>	22c. DATE SIGNED <u>11-12-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-14-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Coloma</u>	23d. LOCATION (City, town, or county) (State) <u>Coloma - Carroll - Mo.</u>
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24. FUNERAL DIRECTOR <u>Dickerson Funeral Home, Bogard, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-13-60</u>	26. REGISTRAR'S SIGNATURE <u>Tom Niekirk Carter</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 30 1980

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 Samuel M. Aire

Licensed Embalmer No. 508

P. O. Address Bogalusa, La.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.