

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012356

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 29

FILED VS MAR 14 1961

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp.</u>		Length of stay in 1b <u>374 1No 22d</u>	c. CITY OR TOWN <u>Joplin</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>State Hosp. # 3 Nevada, Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2204 Grand Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>May</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>61</u>			
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>3-23-82</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (City and state or country) <u>Marion, Ohio</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>O. D. Dewdyer</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Burnes</u>	14. NAME OF HUSBAND OR WIFE <u>unk</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>unk</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT Address <u>Records State Hospital # 3 Nevada, 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>Arterio sclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sev. years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebro spinal Syphilis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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. _____	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 <u>7-1-59</u> to <u>3-6-61</u> and last saw her <u>him</u> alive on <u>3-6-61</u> Death occurred at <u>9:05</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>Nevada Missouri</u>	22c. DATE SIGNED <u>3-6-61</u>
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23a. REMOVAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-7-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>State Anatomical Bld. St. Louis Mo</u>	23d. LOCATION (City, town, or county) (State) <u>Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Hay Funeral Service Inc Nevada, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-8-1961</u>	26. REGISTRAR'S SIGNATURE <u>Anna E Jerry</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Richard L. Griffin

Licensed Embalmer No. 5052

P. O. Address St. Louis, Mo

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.