

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-61-016944  
STATE FILE NUMBER

FILED MAY 16 1961

Registration District No. 86 Primary Registration District No. 4149 Registrar's No. 9-1961

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Crawford</u> <u>0280</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Cuba</u> <u>02802</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>23 Ethel Medical Clinic for Treatment</u>		Length of stay in lb.	d. STREET ADDRESS (If outside, give location) <u>411 Vine St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Marie</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1961</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>Sept. 19, 1910</u>		9. AGE (In years) <u>50</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>23</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self &amp; Wife</u>		11. KIND OF BUSINESS OR INDUSTRY <u>Hammer Bros. Co.</u>	12. BIRTHPLACE (City and state or country) <u>Boston, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Frank Bernhard</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Talliff</u>		14. NAME OF HUSBAND OR WIFE <u>Frank 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></u>		17. INHERENT <u>Frank Miller</u> Address <u>Cuba, Mo.</u>	
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>Acute Posterior Myocardial Infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u>Coronary atherosclerosis</u> <u>4201</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>					
20d. INJURY OCCURRED WHILE AT <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 <u>5-12-61</u> to <u>5-12-61</u> and last saw <sup>her</sup> <del>him</del> alive on <u>5-12-61</u> Death occurred on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Frank A. Shambler, M.D.</u> (Degree or title)			22b. ADDRESS <u>Cuba Mo</u>		22c. DATE SIGNED <u>5-14-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>May 16, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geeth Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Boston Mo.</u>
24. FUNERAL DIRECTOR <u>Frank A. Shambler</u> ADDRESS <u>Cuba, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 15, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Frank A. Shambler</u>	

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

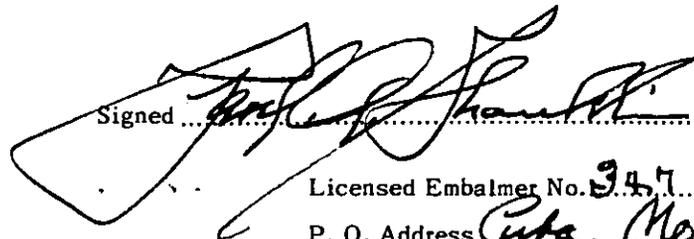
MEDICAL CERTIFICATION

MAY 16 1961

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  .....  
Licensed Embalmer No. 3472  
P. O. Address Cuba, 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.