

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024336

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 50

Primary Registration District No. 5179

Registrar's No. 31

FILED JUL 17 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Camden</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Camden</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osage</u>		Length of stay in 1b <u>16 Months</u>		c. CITY OR TOWN <u>Camdenton</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>Mozark Health Resort</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Lake Road 54-85</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Maxwell</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1961</u>									
5. SEX <u>Female</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>Jan. 24-76</u>		9. AGE (last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
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>At-Home</u>		11. BIRTHPLACE (City and state or country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Un-Known</u>				13b. MOTHER'S MAIDEN NAME <u>Un-Known</u>				14. NAME OF HUSBAND OR WIFE <u>George 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>1</u>		17. INFORMANT <u>Mrs Frances Simpson, Camdenton 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>Cardio Vascular Renal Disease With</u> DUE TO (b) <u>Congestive type Cardiac Failure</u> DUE TO (c) <u>Arteriosclerosis Generalized</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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>2 years</u> <u>10 years</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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from <u>April 1959</u> to <u>July 10-1961</u> and last saw her <u>live</u> on <u>July 9-61</u> Death occurred at <u>5:15 PM July 10-1961</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Thos A. Wayland MD</u>						22b. ADDRESS <u>Camdenton Mo.</u>			22c. DATE SIGNED <u>July 11 1961</u> (State)				
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laughlin Cemetery</u>		23d. LOCATION (City, town, or county) <u>Camden County, Mo.</u>							
24. FUNERAL DIRECTOR <u>Robert H. Reed, Camdenton Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>July 11-1961</u>		26. REGISTRAR'S SIGNATURE <u>Zilpha J. Drew</u>							

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Camden

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.