

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030136

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 217 Primary Registration District No. 5787 Registrar's No. 63

**FILED SEP 6 1961**

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RFD #3 Charleston</u>	Length of stay in 1b <u>1 1/2</u> Years	c. CITY OR TOWN <u>RFD #3 Charleston</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>RFD #3 Charleston</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD #3 Charleston</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Bardie</u> Middle <u>Kinnah</u> Last <u>Miller</u>	4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>61</u>
--	---

5. SEX <u>Male</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>3/1/1902</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </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>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Decatur Co. Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	---	--	---

13a. FATHER'S NAME <u>W.E. Miller</u>	13b. MOTHER'S MAIDEN NAME <u>Masilda Pollard</u>	14. NAME OF HUSBAND OR WIFE <u>Lorene 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>	17. INFORMANT Address <u>Mrs. Lorene Miller, Charleston, 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>Ac. Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
DUE TO (b) <u>A-A heart 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) <u>Coronary Thrombosis July 1959</u>		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

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.) <u>  </u>
---	---	---

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 type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. CITY, TOWN, OR LOCATION <u>  </u>	COUNTY <u>  </u>	STATE <u>  </u>
--	---	---	---------------------	--------------------

21. I attended the deceased from <u>July 12 1959</u> to <u>7/25/61</u> and last saw him alive on <u>6/28/61</u> Death occurred at <u>11:00 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>Charles Kolwing MD</u>	22b. ADDRESS <u>Charleston Mo</u>	22c. DATE SIGNED <u>8/1/61</u>
---	--------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal &amp; Burial</u>	23b. DATE <u>7/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Garden</u>	23d. LOCATION (City, town, or county) (State) <u>Jackson, Tenn.</u>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>The Nunnelee Funeral Chapel Charleston, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-1-61</u>	26. REGISTRAR'S SIGNATURE <u>Lorady B. Hathorn</u>
--	---	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1972

114

**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 Edward E. Hummel

Licensed Embalmer No. 4164

P. O. Address Sikeston, 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.

10-1-72