

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-031976

STATE FILE NUMBER

AMENDED

Registration District No.

042

Primary Registration District No.

1000

913

Registrar's No.

FILED SEP 18 1961

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. COUNTY <u>Buchanan</u>			a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph, Missouri</u>		Length of stay in 1b <u>1 yr. 5mo</u>	c. CITY OR TOWN <u>Rayville, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No #2</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. R. #2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>n.mi.</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____
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>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Weston, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Allie Harmon</u>		14. NAME OF HUSBAND OR WIFE <u>---</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>None</u>		17. INFORMANT <u>Records from State Hospital #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>					<u>over 90 days</u>
DUE TO (b) <u>Arteriosclerosis</u> <u>On set prior to 4-1960.</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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ 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.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>4-1960</u> to <u>9-8-61</u> and last saw him alive on <u>9-7-61</u> Death occurred at <u>7:30 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. Smith M.D.</i> (Degree or title) <u>Staff Physician</u>			22b. ADDRESS <u>State Hospital No. #2</u> <u>St. Joseph, Missouri</u>		22c. DATE SIGNED <u>9-8-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 10, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crowley Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rayville, Missouri</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Sept. 12, 1961</u>		26. REGISTRAR'S SIGNATURE <i>Mr. Clark Goodell</i>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

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 Walter Mischoff

Licensed Embalmer No. 1890

P. O. Address 1946 Colborn
St. Joseph

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.