

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-51-035744**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 002 Primary Registration District No. 4009 Registrar's No. 28

**FILED NOV 6 1961**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Andrew</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Andrew</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Savannah</b>			Length of stay in 1b		c. CITY OR TOWN <b>Savannah</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>408 North Francis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>408 North Francis</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Clyde</b> Middle <b>J.</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-99</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>contractor</b>		11. BIRTHPLACE (City and state or country) <b>Andrew County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Charles K. Miller</b>			13b. MOTHER'S MAIDEN NAME <b>Maude Monroe</b>			14. NAME OF HUSBAND OR WIFE <b>Florence Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Florence Miller, Savannah, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Melanoma with Cerebral Met-asis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
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)					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 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>6-22-55</u> to <u>10-26-61</u> and last saw <u>him</u> <input checked="" type="checkbox"/> alive on <u>10-23-61</u> Death occurred at <u>1:30 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Name or title) <i>William B. Kelley</i>				22b. ADDRESS <b>Savannah, Mo.</b>			22c. DATE SIGNED <b>10-27-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>10-28-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Savannah Cemetery</b>		23d. LOCATION (City, town, or county) <b>Savannah, Missouri</b>		(State)
24. FUNERAL DIRECTOR <b>BREIT &amp; HAWKINS SAVANNAH</b>			25. DATE RECD. BY LOCAL REG. <b>10-31-61</b>		26. REGISTRAR'S SIGNATURE <i>Killian Sparks</i>		

NOV 13 1962

**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 James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.