

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043848

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 500

STATE FILE NUMBER

AMENDED

FILED JAN 2 1962

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CAPE GIRARDEAU</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Byrd township</u> | | c. CITY OR TOWN <u>Byrd township</u> | |
| Length of stay in 1b <u>26 yrs</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>HOME - Rt 2 Jackson - Mo</u> | | d. STREET ADDRESS (If outside, give location) <u>Rt - 2 - Jackson, Mo</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|---|----------------------------------|---|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>ROXIE</u> Middle <u>ANN</u> Last <u>MIRLY</u> | | | 4. DATE OF DEATH Month <u>DEC</u> Day <u>29</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>11/5/1908</u> | 9. AGE (last birthday) <u>53</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, then if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | | 11. BIRTHPLACE (City and state or country) <u>JACKSON - MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME <u>Robert Dickerson</u> | | 13b. MOTHER'S MAIDEN NAME <u>ANNA Loos</u> | | 14. NAME OF HUSBAND OR WIFE <u>Walter O. Mirly</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>Walter O. Mirly - Rt 2, Jackson - Mo</u> | |

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| 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 <u>5 minutes</u> |
| IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> | | | |
| DUPLICATE (b) <u>Unknown</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: | | | |
| DUPLICATE (c) _____ | | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</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 | |
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|---|---|--|-------|
| 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 _____ 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 Sept. 12, 1959 to Dec 19, 1961 and last saw her alive on Dec 19, 1961
Death occurred at 5:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-----------------|---|---|---|--|
| 22a. SIGNATURE <u>Edw. Warren Salzman, D.C.</u> (Degree or title) | | 22b. ADDRESS <u>212 South Union Avenue</u> | | 22c. DATE SIGNED <u>Dec 30</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | <u>12/31/61</u> | <u>RUSSELL HEIGHTS</u> | | <u>JACKSON MO</u> | |
| 24. FUNERAL DIRECTOR <u>McCarrs</u> ADDRESS <u>JACKSON - MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-30-61</u> | 26. REGISTRAR'S SIGNATURE <u>Gene Karter</u> | | |

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 Bruce Perkins

Licensed Embalmer No. 5097

P. O. Address Jackson - 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.