

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-024006

STATE FILE NUMBER

Registration District No. 227 Primary Registration District No. 4239 Registrar's No. 28

FILED JUN 18 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

0690
20690
3
4 0
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9331X
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1290-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PARIS</u>		Length of stay in 1b <u>35 YRS</u>	c. CITY OR TOWN <u>JACKSON TWP.</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>E. MONROE STREET</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2 MI. NDE PARIS</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WINSTON DUDLEY MILLER</u>			4. DATE OF DEATH Month Day Year <u>JUNE 12 1962</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>4/11/1873</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>GENERAL FARMING</u>	11. BIRTHPLACE (City and state or country) <u>MO.</u>
13a. FATHER'S NAME <u>JOE. H. MILLER</u>		13b. MOTHER'S MAIDEN NAME <u>SALLY GOODNIGHT</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED LAURA BELLE BERRY</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>MRS. IDA L. FINNIGAN</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>Cerebral Hemorrhage 3 days after illness</u> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH. <u>3 Days</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 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>June 7</u> to <u>June 12</u> and last saw him alive on <u>June 12</u> . Death occurred at <u>7:55 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wm M. Barnett M.D.</u>		22b. ADDRESS	22c. DATE SIGNED <u>6/12/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6/14/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u>
24. FUNERAL DIRECTOR <u>E. H. AGNEW PARIS, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>6-12-62</u>	26. REGISTRAR'S SIGNATURE <u>W. A. Barnett M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 E. H. Agnew,

Licensed Embalmer No. 4000

P. O. Address Paris, 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.