

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-026852

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 639 Primary Registration District No. _____ Registrar's No. 42

FILED AUG 8 1962

VS 300
Rev. 4/59

1 0440

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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>HOLT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOUND CITY</u>		Length of stay in lb <u>2 YRS</u>	c. CITY OR TOWN <u>MOUND CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>MOUND CITY</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>DORA</u> Last <u>MILES</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>7/15/1878</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IN THE HOME</u>		11. BIRTHPLACE (City and state or country) <u>HOLT Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>WILLIAM SKELLEY</u>		13b. MOTHER'S MAIDEN NAME <u>JANE COTTIER</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM R. MILES</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>SKELLEY MILES, FAIRFAX Mo.</u> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>Cardiac Arrest</u> <u>Myocardial Infarction</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>4 MIN.</u> <u>1 day (24 hours)</u>
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

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.)
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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
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21. I attended the deceased from July 23, 1959 to July 29, '62 and last saw her alive on July 29, '62
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>James Humphrey M.D.</u> (Degree or title)	22b. ADDRESS <u>MOUND CITY, MO</u>	22c. DATE SIGNED <u>7/31/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-31-1962</u>	23c. NAME OF CEMETERY OR CREMATOR <u>NEW LIBERTY</u>	23d. LOCATION (City, town, or county) (Site) <u>HOLT COUNTY, MO.</u>
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24. FUNERAL DIRECTOR <u>James H. Crawford</u> ADDRESS <u>MOUND CITY, MO</u>	25. DATE RECD. BY LOCAL REG. <u>7-31-1962</u>	26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>
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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 *James Benford*
Licensed Embalmer No. 4796

P. O. Address Mount City, 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.