

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035197

STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 163

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

1. PLACE OF DEATH a. COUNTY Jasper b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webb City Length of stay in 1b 56 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jasper c. CITY OR TOWN Webb City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1227 Crow St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Jane Chinn Hospital Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1227 Crow St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Lucy Middle I. Last Miller	4. DATE OF DEATH Month September Day 12 Year 1962
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1877	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) Alliance, Ohio	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME T.W. Buckner	13b. MOTHER'S MAIDEN NAME Lucinda Bell	14. NAME OF HUSBAND OR WIFE WM. F. Miller
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT Mr. Wm. F. Miller 1227 Crow St. Webb City, Mo.
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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: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH few hrs
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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) Myocarditis	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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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"/>
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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 **1942** to **9-12-62** and last saw her/him alive on **9-11-62**
 Death occurred at **6:15A** m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE  (Degree or title) D.O.	22b. ADDRESS Carterville, Missouri	22c. DATE SIGNED 9-12-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-14-62	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) Webb City, Missouri
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24. FUNERAL DIRECTOR ADDRESS Johnston-Simpson, Webb City, Mo.	25. DATE RECD. BY LOCAL REG. 9-13-62	26. REGISTRAR'S SIGNATURE 
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VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Date received at Dr. Office- 9-12-62

Date received back from Dr. Office-- 9-12-62

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 Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address Walt 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.