

FILED SEP 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29254

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>391</u>		PRIMARY REG. DIST. NO. <u>6653</u>		Registrar's No. <u>24</u>	
1. PLACE OF DEATH a. COUNTY <u>Stoddard</u> <u>1030</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bell City (Rural)</u>		c. LENGTH OF STAY (In this place) <u>6 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bell City (Rural)</u> <u>1030</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route 1, Box 37</u>				d. STREET ADDRESS (If rural, give location) <u>Route 1, Box 37</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u> b. (Middle) <u>Matthew</u> c. (Last) <u>Miller</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 21, 1951</u>				
5. SEX <u>Male</u> <u>2</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 22, 1895</u>	
				9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months <u>2</u> Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____
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>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Cotton Plant, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>Popsie Miller</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Popsie Miller, R.1, Bell City, Mo.</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <u>2 years.</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>4222</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:00 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>G. W. Rainey</u> Coroner				23b. ADDRESS <u>Dexter, Missouri</u>		23c. DATE SIGNED <u>8-21-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 25, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		24d. LOCATION (City, town, or county) (State) <u>Dexter, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-1-51</u>		REGISTRAR'S SIGNATURE <u>Bennie Moore</u> <u>360</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. D. Sparks</u>		ADDRESS <u>Charleston, Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

SEP 12 1951

DISTRICT HEALTH OFFICE No.

File No.....

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
Student Embalmer

Signed Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Sable

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 this body is not embalmed, fact should be so stated above.