

FILED AUG 10 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23974**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **846**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Harrison</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph Mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Cainsville (Rural)</b>	
c. LENGTH OF STAY (in this place) <b>34 hrs 5 M</b>		d. STREET ADDRESS (If rural, give location) <b>0410 P.R.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital #2</b>			
3. NAME OF DECEASED a. (First) <b>Rosa</b> b. (Middle) <b>F.</b> c. (Last) <b>Miller</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>7 30 1953</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 10, 1886</b>
9. AGE (In years) (last birthday) <b>67</b>		10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>House wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>
11. BIRTHPLACE (City and State or Foreign Country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>George Miller</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Nil</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>George Miller</b>		ADDRESS <b>1530<sup>th</sup> West Main St</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocarditis chronic</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> ANTECEDENT CAUSES <b>Arteriosclerosis</b> 10 yrs Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>Psychotic</b> 3 1/2 yrs Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4221</b>	
20. AUTOPSY? 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) (Min.)		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 <b>Jan 1, 1953</b> to <b>7-30, 1953</b> that I last saw the deceased alive on <b>7-29, 1953</b> and that death occurred at <b>7:30 a.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>O. E. Cassius M.D.</b>		23b. ADDRESS <b>State Hospital #2</b>	
23c. DATE SIGNED <b>7-30-1953</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-1-53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Public Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Joseph Mo.</b>	
DATE REC'D BY LOCAL REG. <b>Aug 4, 1953</b>		REGISTRAR'S SIGNATURE <b>4850</b> <b>Gertrude M. Allison</b>	
FURNERAL DIRECTOR'S SIGNATURE <b>Stannan W. Sidenfaden</b>		ADDRESS <b>1802 Union St</b>	

(Licensed Embalmer's Statement on Reverse Side) **St. Joseph, Mo.**

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

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 \_\_\_\_\_

*Robert H. Gable*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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 this body is not embalmed, fact should be so stated above.