

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9488

FILED MAR 16 1954

State File No.

BIRTH NO. _____ REG. DIST. NO. 238 PRIMARY REG. DIST. NO. 5821 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>NEW MADRID</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ARKANSAS</u> b. COUNTY <u>VAN BUREN</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>RURAL-BIG PRAIRIE</u>	c. LENGTH OF STAY (in this place) township) <u>5 MONTHS</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u> 8030 y	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <u>REBECCA</u>	b. (Middle) <u>CAROLINE</u>	c. (Last) <u>MILLER</u>	<u>MARCH 1, 1954</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>APRIL 4, 1865</u>		9. AGE (In years last birthday) Months Days Hours Min. <u>88</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>ARKANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>HAMETT</u>		13b. MOTHER'S MAIDEN NAME <u>TRAWICK</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN MILLER</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PULMONARY EMBOLISM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 HRS</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1. HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) 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 SEPT 10 53 to 1 MAR 54, 1954, that I last saw the deceased alive on 1 MAR 54, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Richard L. Jones M.D.</u>		23b. ADDRESS <u>Clinton Ark</u>		23c. DATE SIGNED <u>3.8.54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Mar-2-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Preffler Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Clinton Ark</u>	
DATE REC'D BY LOCAL REG. <u>3-10-54</u>	REGISTRAR'S SIGNATURE <u>Helew Lovd Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Richard L. Jones M.D. 216-0</u> <u>Richards Trust Co. New Madrid</u>		

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

Name of Deceased		Age		Sex	
Date of Death		Place of Death		Cause of Death	
Place of Burial		Name of Undertaker		Address of Undertaker	
Name of Embalmer		Address of Embalmer		Date of Embalming	
Signature of Embalmer		Signature of Undertaker		Signature of Witness	

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

working under my personal supervision. Student Embalmer No. _____

Student _____ Signed: *James L. Roberts*

Licensed Embalmer No. *4886* P. O. Address *New Rochelle*

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.