

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

Miller
State File No. **29622**

FILED SEP 27 1955

BIRTH NO. _____		REG. DIST. NO. <u>142</u>		PRIMARY REG. DIST. NO. <u>4231</u>		Registrar's No. <u>37</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>			
b. CITY OR TOWN <u>Mtn. View</u>		c. LENGTH OF STAY (in this place) <u>5485</u>		c. CITY OR TOWN <u>Mtn. View</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) <u>0460</u>			
3. NAME OF DECEASED (Type or Print) <u>Dovie</u>			a. (First) _____ b. (Middle) _____ c. (Last) <u>THOMAS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28-1955</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED/ WIDOWED, DIVORCED (Specify) <u>M.</u>		8. DATE OF BIRTH <u>March 6-1892</u>	
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR: Months <u>5</u> Days <u>22</u>		IF UNDER 12 HRS. Hour _____ 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 _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Texas Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>John Spiva</u>			13b. MOTHER'S MAIDEN NAME <u>MARY ANDERSON</u>			14. NAME OF HUSBAND OR WIFE <u>Ambrose Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Ambrose Thomas</u>		ADDRESS <u>Mtn. View, 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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u>					<u>4 years</u>
		DUE TO (c) <u>Hypertension</u> for <u>years</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Obesity-</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>331x.</u>					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) _____		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 <u>aug-24th</u> , 19 <u>55</u> , to <u>aug-28th</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>aug-28</u> , 19 <u>55</u> , and that death occurred at <u>2:30</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Harold W. Miller M.D.</u>				23b. ADDRESS <u>Willow Springs Mo.</u>		23c. DATE SIGNED <u>9/25-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>Aug 29-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City</u>		24d. LOCATION (City, town, or county) (State) <u>Mtn. View, Mo.</u>	
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Duncan & Helin</u>		ADDRESS <u>0460</u>	

(Licensed Embalmer's Statement on Reverse Side)

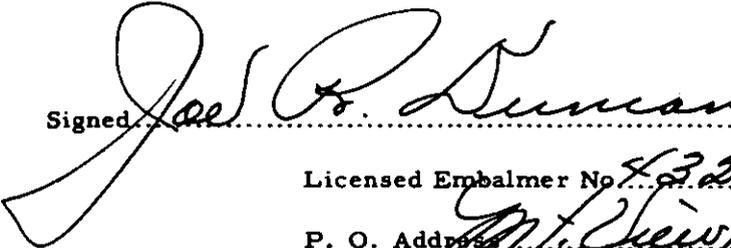
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

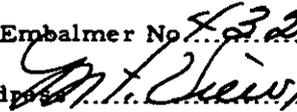
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 432

P. O. Address 

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.