FILED MAY 23 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15445
State File No.

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 5002 Registrar's No. 150

1. PLACE OF DEATH
a. COUNTY Adair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Liberty Twp.
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8 mi S. of Green Castle

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Sullivan 1050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Green City
d. STREET ADDRESS (If rural, give location) No street address

3. NAME OF DECEASED (Type or Print)
a. (First) Lone
b. (Middle) Claude
c. (Last) Miracle

4. DATE OF DEATH (Month) (Day) (Year) May 15, 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH Oct. 8, 1887
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months ___ Days ___ — IF UNDER 24 HRS. Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Samp Brashears
13b. MOTHER'S MAIDEN NAME Lee Corley
14. NAME OF HUSBAND OR WIFE J. A. Miracle-Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ———
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Quail Hill, Green Castle, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH 5 yrs

ANTECEDENT CAUSES

Morbid 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

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 4222
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 8, 1947, *to* May 15, 1956, *that I last saw the deceased alive on* May 5, 1956, *and that death occurred at* 8:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) R D Smith DO
23b. ADDRESS 2 Green City, Missouri
23c. DATE SIGNED 5/17/56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE May 21, 1956
24c. NAME OF CEMETERY OR CREMATORY Cass Cemetery
24d. LOCATION (City, town, or county) (State) Cass, Arkansas

DATE REC'D BY LOCAL REG. 5-18-56
REGISTRAR'S SIGNATURE Kate Lambert
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Glenn E. Kentson, Green City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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