

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5878

FILED MAR 5 1957

STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Raymond Township</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Osick</u> 0890 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital Day</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>Street not listed</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Elvis</u> Middle <u>William</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1913</u>		9. AGE (In years last birthday) <u>63</u> IF UNDER 1 YEAR Months <u>5</u> Days <u>29</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent Telegrapher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Lexington, Missouri</u>	
13. FATHER'S NAME <u>John Miller</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Hunt</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Edith Miller, Osick, Missouri</u> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____ STATE _____

21. I attended the deceased from Feb 1 - 57 to 2-22-57 and last saw her alive on 2-22-57. Death occurred 5:30 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. B. Ray M.D.</u> (Degree or title)	22b. ADDRESS <u>Raymond, Missouri</u>	22c. DATE SIGNED <u>2-25-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 25, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial City Cem., Missouri City, Missouri</u>
23d. LOCATION (City, town, or county) <u>Missouri City, Missouri</u>	24. FUNERAL DIRECTOR <u>Richardson, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 25 - 1957</u>
26. REGISTRAR'S SIGNATURE <u>Malcol Jackson</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
300-56
Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no disease. AT
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Received Feb 25

MAR 18 1957

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 *[Handwritten Signature]*.....
Licensed Embalmer No. *5400*

P. O. Address *[Handwritten Address]*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.