

Health,
Welfare
Public
Service

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300
1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013685
STATE FILE NUMBER

FILED MAY 13 1958

Registration District No. 93 Primary Registration District No. 4156 Registrar's No. 58-33

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>So Greenfield Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>So Greenfield Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>			Length of stay in 1b <u>YRS</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Artie</u> Middle <u>Caroline</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1958</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>July 28 1888</u>		9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</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		11. BIRTHPLACE (City and state or country) <u>Dade Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Martin M Merrick</u>				14. MOTHER'S MAIDEN NAME <u>Collie Williamson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>George W Miller So.Greenfield Mo.</u>					
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>Paralytic agitans</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		350X			
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 <u>12:45A</u> Month <u>3</u> Day <u>1</u> Year <u>58</u> a. m. <u>12:45A</u> p. m.									
20d. INJURY OCCURRED WHILE AT WORK <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 <u>Greenfield Mo</u>		COUNTY		STATE	
21. I attended the deceased from <u>3-1-58</u> to <u>5-3-58</u> and last saw ^{her} him alive on <u>5-3-58</u> Death occurred at <u>12:45A</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Dr. O. Corvan M.D.</u>				22b. ADDRESS <u>Greenfield Mo</u>				22c. DATE SIGNED <u>5-5-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 4 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pennsboro</u>		23d. LOCATION (City, town, or county) <u>Dade Co Mo.</u>				(State)	
24. FUNERAL DIRECTOR <u>W.R. Allison</u> ADDRESS <u>Greenfield Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5-6-1958</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>				

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 *W.R. Allison*.....

Licensed Embalmer No. *44*

P. O. Address *Greenville*

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