

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024540

STATE FILE NUMBER

FILED JUL 25 1958 Registration District No. 27 Primary Registration District No. 5097 Registrar's No. 100

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Bates</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural-Shawnee Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>00700</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <b>3 Years</b>	d. STREET ADDRESS (If outside, give location) <b>Shawnee Twp.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last <b>Barbra Martha Miller</b>			4. DATE OF DEATH Month Day Year <b>July 5 1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18 1876</b>
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Hwfe.</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Wilksbury Penn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Henry Fastabend.</b>	
13b. MOTHER'S MAIDEN NAME <b>Catherine Getz.</b>		14. NAME OF HUSBAND OR WIFE <b>William Henry Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Albert Miller, Adrian, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Edema of lungs</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cirrhosis of liver</b> DUE TO (c) <b>generalized edema &amp; ascites</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1 yr.</b> <b>1 yr.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		<b>5810</b>	
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 Month, Day, Year a.m. p.m.		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 <b>7-25 1949</b> , to <b>7-4-1958</b> and last saw <sup>her</sup> alive on <b>June 30 1958</b> Death occurred at <b>12:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>D.S. Colson D.O. I</b>		22b. ADDRESS <b>Adrian Mo</b>	
22c. DATE SIGNED <b>July 7 1958</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-8-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crescent Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Adrian, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Six Funeral Service, Adrian, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>July 8-1958</b>	26. REGISTRAR'S SIGNATURE <b>Kendall Kurray</b>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

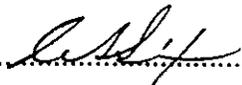
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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..3650.....

P. O. Address...Adrian, Mo.....

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.