

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031737
STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 449

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <i>Boone</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Boone</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Columbia</i> 0105 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Sandford Rest Home</i>		Length of stay in 1b <i>3 years</i>	d. STREET ADDRESS (If outside, give location) <i>3016 5th St.</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>VERGIL</i> Middle Last <i>MILLER</i>			4. DATE OF DEATH Month <i>Oct.</i> Day <i>6</i> Year <i>1958</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 18 - 1884</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i>		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) <i>74 yr.</i> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i>		10b. KIND OF BUSINESS OR INDUSTRY	10c. BIRTHPLACE (City and state or country) <i>Boone County Mo.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <i>Albert M. Miller</i>		13b. MOTHER'S MAIDEN NAME <i>Jane Cochran</i>	14. NAME OF HUSBAND OR WIFE <i>none</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Albert Miller</i> Address <i>Columbia, Mo.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<i>331X</i>
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. _____			
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 Death occurred at <i>June 28, 1956</i> to <i>6 Oct 58</i> and last saw him alive on <i>Oct 2, 1958</i> <i>4:30 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (If one of title) <i>Lloyd J. Miller M.D.</i>		22b. ADDRESS <i>22 N. 8th Columbia Mo.</i>	22c. DATE SIGNED <i>7 Oct 58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 8, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rochepart</i>
23d. LOCATION (City, town, or county) (State) <i>Rochepart, Mo.</i>			
24. FUNERAL DIRECTOR <i>Mrs. Stuart Parker, Columbia, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Oct. 7, 1958</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. R.E. Palmer</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.
No symptoms will be listed.

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 *Georgette Green*

Licensed Embalmer No. *4220*

P. O. Address *Marshall 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.

(2) 9/17/88