

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011821

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 381 Primary Registration District No. 3039 Registrar's No. 56

FILED MAR 29 1962

VS 300
Rev. 4/59

1 0581

2 0581

3 2

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7 0

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9 1533

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12 4-0

13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		c. CITY OR TOWN <u>MARCELINE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>214 W. HOWELL</u>	
3. NAME OF DECEASED (Type or print) First <u>GILBERT</u> Middle <u>IVAN</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1962</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>8-27-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ATSF RAILROAD</u>	11. BIRTHPLACE (City and state or country) <u>CHARITON, CO. MO.</u>
13a. FATHER'S NAME <u>THOMAS MILLER</u>		13b. MOTHER'S MAIDEN NAME <u>LOU HAGAN</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>		17. INFORMANT <u>TOM MILLER</u> Address <u>MARCELINE</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>Intestinal Obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of Sigmoid Colon</u>			<u>Indefinite</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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	COUNTY _____ STATE _____
21. I attended the deceased from <u>Oct 1961</u> to <u>Mar 23, 62</u> and last saw ^{her} him alive on <u>Mar 23, 62</u> Death occurred at <u>3:20 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Shannon A. Hanner, MD</u>		22b. ADDRESS <u>Marceline, Mo.</u>	22c. DATE SIGNED <u>3-24-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-26-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. BONAVENTURE CEM</u>	23d. LOCATION (City, town, or county) (State) <u>MARCELINE MO.</u>
24. FUNERAL DIRECTOR <u>MILLER-Tillotson</u> ADDRESS <u>MARCELINE</u>		25. DATE RECD. BY LOCAL REG. <u>3-24-62</u>	26. REGISTRAR'S SIGNATURE <u>Carroll Watson</u>

APR 18 1962

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 Libbun B. Tillatson

Licensed Embalmer No. 4508

P. O. Address Macedonia 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.