

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-015353

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 64 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED MAY 14 1963**

VS 300  
Rev. 4/59

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122-0

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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 <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		Length of stay in 1b <b>23 years</b>	c. CITY OR TOWN <b>Excelsior Springs,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Excelsior Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1216 Curtis</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Roscoe</b> Middle <b>Miller</b> Last <b>Miller</b>			4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/11/1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paint filler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paint</b>	9. AGE (last birthday) <b>69</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11a. FATHER'S NAME <b>Ben Miller</b>		11b. MOTHER'S MAIDEN NAME <b>Rachel Miller</b>	11. BIRTHPLACE (City and state or country) <b>Dexter, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		14. NAME OF HUSBAND OR WIFE <b>Dorothy Roberson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of <b>No</b> )		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs Dorothy Miller, Excelsior Springs, Mo</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Myocardial Infarction (Sept)</b> <b>(2) Arteriosclerosis (Complete)</b> <b>24 hours</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertensive Heart Disease</b> <b>10 years.</b>			INTERNAL BETWEEN INSUREMENTS <b>24 hours</b> <b>year</b> <b>10 years.</b>
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 checked="" 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.	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 <b>1955</b> to <b>5-3-63</b> and last saw her him alive on <b>5-3-63</b> Death occurred at <b>10</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Raymond P. Prochance M.D.</b>		22b. ADDRESS <b>Excelsior Springs, Mo.</b>	22c. DATE SIGNED <b>5-3-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/6/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill</b>	23d. LOCATION (City, town, or county) <b>Excelsior Springs, Mo</b>
24. FUNERAL DIRECTOR <b>Richard Funeral Home, Inc.</b> <b>Excelsior Springs, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>5-3-63</b>	26. REGISTRAR'S SIGNATURE <b>Coraline Stuchings</b>

MAY 22 1963

Permit received 5-6-63 C.A.

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

*Ralph Van Landingham*

Licensed Embalmer No. 4009

*Quincy Springs, Mo*

P. O. Address

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.