

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033126

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 314

FILED SEP 12 1963

VS 300	DATE AMENDED
Rev. 4/59	
10808	
20808	
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4 1	
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9420.1	
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12 90-0	
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1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA, Mo.</u> Length of stay in 1b <u>6 2 yrs.</u>		c. CITY OR TOWN <u>SEDALIA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>222 E. 6th.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DELL</u> Middle <u>LERIA</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>SEP</u> Day <u>9</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 8, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Blackwater Mo.</u>
13a. FATHER'S NAME <u>Dr. CHARLES GREEN</u>		13b. MOTHER'S MAIDEN NAME <u>JENNIE</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. _____	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction aut. Wall.</u> DUE TO (b) <u>arterio Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		17. INFORMANT <u>Guy Miller, Seattle, Wash.</u> Address _____ INTERVAL BETWEEN ONSET AND DEATH _____	
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 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. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>9/9/63 10 am</u> to <u>9/9/63 4:40 p</u> and last saw her <u>alive</u> on <u>9/9/63</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED (State) <u>9/10/63</u> <u>Mo.</u>	
22a. SIGNATURE (Degree or title) <u>Edw. Boyer M.D.</u>		22b. ADDRESS <u>Sedalia Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sep. 12, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown Hill Cem. Sedalia</u>	
23d. LOCATION (City, town, or county) _____		24. FUNERAL DIRECTOR <u>McLaughlin Bros. Sedalia Mo</u> ADDRESS _____	
25. DATE RECD. BY LOCAL REG. <u>Sept 10, '63</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u> <u>per M. Anderson</u>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 27 1963

OCT 18 1963

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 K.P. Lary

Licensed Embalmer No. 3153

P. O. Address S. Lakota

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.