

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-049022

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 280 Primary Registration District No. 5959 Registrar's No. 70

STATE FILE NUMBER

FILED DEC 31 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY <b>Platte</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Platte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fair Township</b>		Length of stay in 1b <b>67 years</b>	c. CITY OR TOWN <b>Platte City, Missouri</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fair Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Fair Township</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Elgin</b> Last <b>Miller</b>			4. DATE OF DEATH Month <b>December</b> Day <b>16</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>3-22-1896</b>
9. AGE (last birthday) <b>67 years</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HOURS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and state or country) <b>Platte City, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Edward Robert Miller</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Elgin</b>		14. NAME OF HUSBAND OR WIFE <b>Oma Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	17. INFORMANT <b>Oma Miller Platte City, Missouri</b> Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Acl</b> DUE TO (b) <b>ASIA</b> DUE TO (c) <b>Generalized AS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>WY</b> <b>WY</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Parkinsons Disease</b>			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 <b>1950</b> to <b>1963</b> and last saw her/him alive on <b>12/16/63</b> Death occurred at <b>7:30 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>H. Graham</b>		22b. ADDRESS <b>Platte City</b>	22c. DATE SIGNED <b>12/10</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-19-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Platte City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Platte City, Missouri</b>
24. FUNERAL DIRECTOR <b>Tommy R. Rollins</b> ADDRESS <b>Platte City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-19-1963</b>	26. REGISTRAR'S SIGNATURE <b>Alphia Rollins</b>

VS 300 Rev. 4/59  
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DATE AMENDED  
INSTEAD OF  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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

*L. P. Polkin*

Licensed Embalmer No. 5110

P. O. Address Platte City, 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.