

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9171

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 224 PRIMARY REG. DIST. NO. 5796 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY MONITEAU		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MONITEAU	
b. CITY (If outside corporate limits, write RURAL and give town or township) CALIFORNIA		c. CITY (If outside corporate limits, write RURAL and give township) CALIFORNIA <u>0680</u>	
c. LENGTH OF STAY (in this place) LIFE		d. STREET ADDRESS (If rural, give location) California Mo Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home Rural			

3. NAME OF DECEASED (Type or Print) JOSEPH HENRY MILLER			4. DATE OF DEATH (Month) (Day) (Year) MARCH 27, 52		
a. (First)		b. (Middle)		c. (Last)	

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 4/24/1857	9. AGE (In years last birthday) 94	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) CLEVELAND, OHIO /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CASPER MUELLER	13b. MOTHER'S MAIDEN NAME CATHERINE	14. NAME OF HUSBAND OR WIFE SOPHIA EDER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME MRS. F.E. OSTERLY, CALIFORNIA, MO.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Lobar Pneumonia DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN OR TOWNSHIP (COUNTY) (STATE) California Moniteau MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Mar. 16, 1952 to Mar. 27, 1952, that I last saw the deceased alive on Mar. 27, 1952, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE L. J. Bawion D.O.	23b. ADDRESS California	23c. DATE SIGNED 3/29/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 3/30/52	24c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S LUTHERAN	24d. LOCATION (City, town, or county) (State) CALIFORNIA, MONITEAU, MO
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DATE REC'D BY LOCAL REG. 4-5-52	REGISTRAR'S SIGNATURE NR Popajoy L 202	25. FUNERAL DIRECTOR'S SIGNATURE ILLIAMS FUNERAL HOME, CALIFORNIA, MO.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

680

No. 300
10-48

APR 9 1952

APR 11 1952

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

H. E. Friedman

Signed.....
Student Embalmer

Licensed Embalmer No. *2854*

P. O. Address *California 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 this body is not embalmed, fact should be so stated above.