WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Schuyler

Township Salt River

or

Village

or

City (NO. , St.; Ward)

Registration District No. 804

Primary Registration District No. 6649

File No. 40086

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Edith Opal Miller

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Single

DATE OF BIRTH Jan (Month) 13 (Day), 1911 (Year)

AGE yrs. 9 mos. 24 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) — 0

BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS

NAME OF FATHER Daniel Henry Miller

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo

MAIDEN NAME OF MOTHER Annie Paulina Ladwig

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Henry Miller

(ADDRESS) Green Cop Mo

Filed 11/7, 1911. F. B. Farrington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov (Month) 7 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 31, 1911, to Nov 7, 1911, that I last saw her alive on Nov 6, 1911, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria

10 9

(Duration) yrs. mos. 7 ds.

Contributory (SECONDARY) None

(Duration) yrs. mos. ds.

(Signed) F B Farrington M. D.

11/7, 1911 (Address) Green Cop Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Green Cop Mo

DATE OF BURIAL Nov 7, 1911

UNDERTAKER L E Young

ADDRESS Green Cop

WRITE PLAINLY, WI[illegible] FADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALT[illegible]
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....(NO....., ...St.;.....Ward)

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

[If death occurred [illegible] hospital or institut[illegible] give its NAME ins[illegible] of street and number

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 19..
(Month) (Day) (Y[illegible]

I HEREBY CERTIFY, that I attended deceased f[illegible]
....., 191...., to....., 191[illegible]
that I last saw h.....alive on....., 191[illegible]
and that death occurred, on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed)..... M[illegible]

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, s[illegible] (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191..
UNDERTAKER	ADDRESS