LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING 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 HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

30818

1 PLACE OF DEATH

County Shelby

Township ~~Black Creek~~ Registration District No. 831 File No.

or

Village Primary Registration District No. 4804 Registered No. 23

or

City Shelbyville (NO. St.; Ward)

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

2 FULL NAME Humphrey B. Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Apr. 24 (Month) (Day) 1851 (Year)

7 AGE 69 yrs. 4 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Kinsley Mo.

PARENTS

10 NAME OF FATHER Joel T. Miller

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

12 MAIDEN NAME OF MOTHER Ludissa Truitt

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Miller

(Address) Bethel. Mo.

15 Filed 8-7, 1920 Wm. Calvin Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 6 (Month) (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 28, 1920, to Sept 6, 1920, that I last saw him alive on Sept 6, 1920, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
131
137
135B | 20

(Duration) X yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Cystitis + Prostatic hypertrophy

(Duration) X yrs. X mos. X ds.

(Signed) P. C. Archer M. D.

Sept 7, 1920 (Address) Shelbyville Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Pleasant Prairie Cem. DATE OF BURIAL Sept. 8, 1920

20 UNDERTAKER J. W. Thompson Son ADDRESS Shelbyville, Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

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

2 FULL NAME .....

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE
..... yrs. ..... mos. ..... ds.

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day) ..... 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

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

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
....., 191..... (Address) .....

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....

20 UNDERTAKER	ADDRESS