26 1927

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

Do not use this space.

1. PLACE OF DEATH
County: Lafayette
Township: Dover
City: Con. Home (No. ..... St. ..... Ward)
Registration District No. H60
Primary Registration District No. 5623-B
File No. 19948 a
Registered No. 92

2. FULL NAME: Arch Miller
(a) Residence. No. Confederate Home St., ... Ward, ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Dont Know

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: —

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1835

7. AGE: Years 91 | Months Dont | Days Know | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Inmate of
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Do not Know

PARENTS
10. NAME OF FATHER: Do not Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Do not Know
12. MAIDEN NAME OF MOTHER: Do not Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Do not Know

14. INFORMANT: Mrs Wilson (Nurse)
(Address): Higginsville Mo

15. FILED 6-12, 1926 Bessie P Porter, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): June-11 1926

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1925, to June 11th, 1926 that I last saw him alive on June 11th, 1926, and that death occurred, on the date stated above, about 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile Pneumonia, & Uremia
91
13 yrs
91B
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Arterial Sclerosis & Insufficiency Arterial Sclerosis Insufficiency
(duration) 3 yrs. ..... mos. 15 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical
(Signed) W H Porter, M. D
, 19 (Address) Higginsville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Confederate Home
DATE OF BURIAL: June 12 1926

20. UNDERTAKER: A H Hader
ADDRESS: Higginsville

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