

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

Do not use this space.

32995

1. PLACE OF DEATH

County Clay Registration District No. 198
 Township Indian River Primary Registration District No. 3011
 City Excelsior Springs No. _____ St. _____ Ward _____

File No. _____
 Registered No. 129

2. FULL NAME

Julia Anna Miller
 (a) Residence No. 442 Bluff St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 40 yrs. mos. _____ ds. How long in U.S., if of foreign birth? yrs. mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE Thomas W Miller

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 - 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
82 10 17

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cass Mo

10. NAME OF FATHER B. W. Mitchell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Margaret Franklin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Margaret Miller (Address) Excelsior Springs Mo

15. FILED 11-2 19 27 J. H. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-2 19 27

17. I HEREBY CERTIFY That I attended deceased from Jan. 27 to Nov. 2nd. 19 27
 or alive on Nov. 1st. 19 27 and that death occurred, on the date stated above, at 1 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Bladder

CONTRIBUTORY (SECONDARY) None (duration) _____ yrs. _____ mos. _____ 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? none

(Signed) E. F. Beckwith, M. D. (Address) Excelsior Springs 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 Salem. DATE OF BURIAL 11-4 19 27

20. UNDERTAKER Herbert Hope Excelsior Springs

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.

