

24 1928

19771-a

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

Do not use this space.

19771-a

1. PLACE OF DEATH

County Madison
Township Waters
City Efford

Registration District No. 4
Primary Registration District No. 5007

File No. _____
Registered No. 48-127
St. _____ Ward)

2. FULL NAME

Juan Cleo Miller

(a) Residence No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 9 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
11 9 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(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) Mo

10. NAME OF FATHER Andrew Miller

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

12. MAIDEN NAME OF MOTHER Alma C. Casey

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

14. INFORMANT Andrew Miller
(Address)

15. FILED 8/30 1928 Ed Becker
REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1928

17. I HEREBY CERTIFY, That I attended deceased from June 30 1928 to June 30 1928, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Intussusception
12 2 13 (duration) yrs. mos. ds. 2
CONTRIBUTORY (SECONDARY) 1/80 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, his home

1 DID AN OPERATION PRECEDE DEATH. Yes DATE OF 6-29-28
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS X-ray
(Signed) J. Foster, M. D.
, 19 (Address) Laurel Wb.

*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 Graven Hill DATE OF BURIAL July 1 1928

20. UNDERTAKER Wm McCallum ADDRESS South Efford

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.

1928-6-30
1927-10-9

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