V 22 1928

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

Do not use this space.

34009

File No. 97

Registered No.

1. PLACE OF DEATH
County: Jefferson
Township: Nate
City: (No. ; St. Ward)
Registration District No.: 4 r o
Primary Registration District No.: 5574

2. FULL NAME: Anna 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: X
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 10 1855

7. AGE: Years 73 | Months 6 | Days 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(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): Switzerland

PARENTS

10. NAME OF FATHER: Jake Miller
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Switzerland
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Switzerland

14. INFORMANT: C. Miller
(Address): Desoto Mo

15. FILED: Nov 1928 D. L. Pangyly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 16 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1928, to [redacted] that I last saw h[redacted] alive on 10/14/28, and that death occurred, on the date stated above, at 4:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Obstruction

(duration) Days yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Dont Know.
(duration) Dont Know yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Not Known.
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) N. H. Farrer, M. D.
, 19 (Address) De Soto 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: City Cem Desoto — DATE OF BURIAL: Oct 18 1928

20. UNDERTAKER: C. P. Barnhart — ADDRESS: De Soto Mo

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jefferson — Registration District No. 420 — File No.
Township Valle — Primary Registration District No. 5574 — Registered No. 92
City (No. , St. Ward)

2. FULL NAME Anna 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

Please state cause of intestinal obstruction.

Do not Remed.
W. H. Farrar

PARENTS
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 1/10 19 28 D. L. Rauggly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal Obstruction
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

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18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

ENT RECORD
LY. PHYSICIANS should state OCCUPATION is very important.
ETE AS PRESCRIBED BY LAW
WRITE PLAINLY
N. B.—Every item of information s CAUSE OF DEATH in plain terms.
REGISTRARS SHALL NOT RECEIV

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