

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

Do not use this space.

11110

1. PLACE OF DEATH

County Jackson
Township Prairie
City..... (No.....).....

Registration District No. 400
Primary Registration District No. 555 P 19

File No.....
Registered No. 46
St..... Ward.....

2. FULL NAME Mellie Miller

(a) Residence. No. Jackson County House 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(write the word)
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1878
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
51 unknown

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) Oklahoma

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

14. INFORMANT J.W. Hostetter
(Address).....

15. Mich 19 29 J.A. James
FILED..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mich 19 - 19 29

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1929 to Mich 19 1929
that I last saw h. or alive on May 18 1929 and that death occurred, on the date stated above, at 10 21 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronic gastroenteritis

1205
114B
CONTRIBUTORY (SECONDARY).....
(duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED ?
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) J.W. Greene M. D.
3/19 1929 (Address) Independence Mo

*State the DISEASE CAUSING DEATH, of 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 Rehearsal of cemetery - Surgery DATE OF BURIAL 3-19 1929

20. UNDERTAKER No. State Anatomical Society ADDRESS Kennett
Kennett

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.

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