

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

Do not use this space.

20820

1. PLACE OF DEATH

County Butler

Registration District No. 89

Township Poplar Bluff

Primary Registration District No. 3007

City Poplar Bluff

File No. 113

Registered No. 113

St. _____ Ward _____

2. FULL NAME

Clyde H. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M- 4. COLOR OR RACE W- 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced.

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23, 1929

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF not known.

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1929 to June 23, 1929 that I last saw him alive on June 23, 1929, and that death occurred, on the date stated above, at 10:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock caused from severe burns.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1904 Est.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 25 Est.

181 (duration) _____ yrs. _____ mos. 2 ds.

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

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

9. BIRTHPLACE (CITY OR TOWN) Hartford (STATE OR COUNTRY) Kan

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

10. NAME OF FATHER Chas. Miller

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

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

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

12. MAIDEN NAME OF MOTHER Jimmie M. Ewan 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Clair (STATE OR COUNTRY) Mo.

(Signed) J. W. [Signature], M. D.

(Address) Poplar Bluff, 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.

14. INFORMANT L. E. Ewan - (Address) Ottawa Kan.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ottawa, Kan. DATE OF BURIAL ?

15. FILED 6/24-29 19 29 REGISTRAR Frank [Signature] - Co. Poplar Bluff

20. UNDERTAKER Frank [Signature] - Co. Poplar Bluff ADDRESS _____

ed. AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important.

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**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 Butler
Township Doplar Bluff
City Doplar Bluff No. _____

Registration District No. 89
Primary Registration District No. 3007

File No. _____
Registered No. 113
St. _____ Ward)

2. FULL NAME

(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Div</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

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

10. NAME OF FATHER

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 July 7, 29 S. B. Clure REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1929

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:

Shock caused from severe burns of clothing burned.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

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.

*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

20. UNDERTAKER

ADDRESS

THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it can be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS MUST RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY 1779

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