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

Do not use this space.

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1. PLACE OF DEATH

County: Andrew, Registration District No.: 16

Township: Rochester, Primary Registration District No.: 7820

City: Rochester, (No. Rochester, Missouri, St. Ward)

File No.:

Registered No.: 1

2. FULL NAME Samuel William Miller,

(a) Residence. No. Rochester, Mo. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 10, 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	72	3	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Carpenter,

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ray County, (STATE OR COUNTY) Missouri,

PARENTS

10. NAME OF FATHER Samuel W. Miller,

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown, (STATE OR COUNTY) Switzerland,

12. MAIDEN NAME OF MOTHER Elizabeth Krebbs,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown, (STATE OR COUNTY) Switzerland,

14. INFORMANT Mrs. S. W. Miller
(Address) Rochester, Missouri.

15. FILED Jan 18, 1930 Mrs Bettie Boggess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jany 16th 1930

17. I HEREBY CERTIFY, That I attended deceased from Jany 15th, 1930, to Jany 16th, 1930, that I last saw h. alive on Jany 16th, 1930, and that death occurred, on the date stated above, at 4:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Perforated Gall Bladder

J 1278

1278 (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) 1216 1

(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?

(Signed) E. M. Reynolds, M. D.

Jan 18, 1930 (Address) Union Star, 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	DATE OF BURIAL
Rochester, Missouri,	Jan. 19 1930
20. UNDERTAKER	**ADDRESS**
F. A. Bowman	Savannah, 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.

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MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Andrew — Registration District No.: 16 — File No.:
Township: Rochester — Primary Registration District No.: 5020 — Registered No.:
City: (No. , St. Ward)

2. FULL NAME: Samuel William Millen

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

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.

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)

PARENTS
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 Jan 18 1920 Mrs. Bettie Boggess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 1930

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:
Perforated gall bladder
Infected gall bladder
Possible stones in bladder
(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
, 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

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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