

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

Do not use this space.

909

**PLACE OF DEATH**

County *Henry*  
Township *Montrose*  
City *Montrose* (No. ....)

Registration District No. *352*  
Primary Registration District No. *4209*

File No. ....  
Registered No. *One*  
St. .... Ward)

2. FULL NAME *Maria L. 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sep. 7. 1888*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
*71 4 10*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *School Teacher*  
(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 *James M. Miller*

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

12. MAIDEN NAME OF MOTHER *Artemesia Elledge*

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

14. INFORMANT *J. Miller*  
(Address) *Montrose Mo*

15. FILED *Jan. 15. 1930* *J. Miller*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 17 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 14* 19*30*, to *Jan. 17* 19*30*, that I last saw him alive on *Jan. 17* 19*30* and that death occurred, on the date stated above, at *3:25 P* m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Lobar Pneumonia*

CONTRIBUTORY (SECONDARY) *101A*  
(duration) yrs. mos. ds.

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

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

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Spiced Lung*  
(Signed) *R. J. Smith* M. D.  
, 19 (Address) *Appleton City 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

*Beav Creek* *Jan. 19 1930*

20. UDBERTAKER *J. L. Murtz* ADDRESS *Montrose*

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.

*18 1930*  
*22*  
*27*  
*30*

*213*  
*1*  
*2*

PARENTS

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