

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

Do not use this space.

944

**1. PLACE OF DEATH**

County Harrison  
Township Chautau  
City (No. .... St. .... Ward)

Registration District No. 379  
Primary Registration District No. 3529

File No. ....  
Registered No. ....

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 19 ds. How long in U.S., if of foreign birth? 72 yrs. 10 mos. 19 ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>72</u>	<u>10</u>	<u>19</u>		

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

9. BIRTHPLACE (CITY OR TOWN) Not known  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Mathew Miller

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

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known  
(STATE OR COUNTRY)

14. INFORMANT Martha A Miller  
(Address) Glasgow Mo

15. FILED 2-1-1930 Ch Temple  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-29 1930

17. I HEREBY CERTIFY, That I attended deceased from 1 27 1930, to 7-29 1930 that I last saw him alive on 1-28 1930 and that death occurred, on the date stated above, at 8:30 pm

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Broncho pneumonia  
11 P  
10 7 11

(Duration) ..... yrs. .... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Influenza  
(duration) ..... yrs. .... mos. 2 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) W. B. Kitcher, M. D.

1-30 1930 (Address) Glasgow

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Glasgow Mo DATE OF BURIAL 1-31 1930

UNDERTAKER Harry Miller ADDRESS Glasgow 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.

4524 1930

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2  
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1950

RECEIVED

OFFICE OF THE ATTORNEY GENERAL

STATE OF TEXAS

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1950

RECEIVED

OFFICE OF THE ATTORNEY GENERAL

STATE OF TEXAS

**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 Howard Registration District No. 379 File No. ....  
 Township Chariton Primary Registration District No. 3529 Registered No. ....  
 City (No. ....) St. .... Ward)

**2. FULL NAME**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-10-1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
72 10 19

**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 3-1-30 Ch Temple REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 1930

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

446-5