

SEP 22 1930

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

Do not use this space.

22229

1. PLACE OF DEATH

County Cass
Township Coldwater
City Greene (No. _____)

Registration District No. 151
Primary Registration District No. 408.5

File No. _____
Registered No. 7
St. _____ Ward _____

2. FULL NAME

Clarence Miller

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

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 16 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 11 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Waco, Mo
(STATE OR COUNTRY)

10. NAME OF FATHER W. M. Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Franklin, Kans.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Maude Dickinson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Westwater, Mo.
(STATE OR COUNTRY)

14. INFORMANT W. M. Miller
(Address) Pittsburg, Kans.

15. FILED July 20 1930 John S. Bundy REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1930

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 27, 1930 that I last saw him alive on July 27, 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute attack of diarrhea
1854
8213
19013 (duration) yrs. mos. ds. 2

CONTRIBUTORY (SECONDARY) Paralysis due to
Hall, June 15, 28, (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

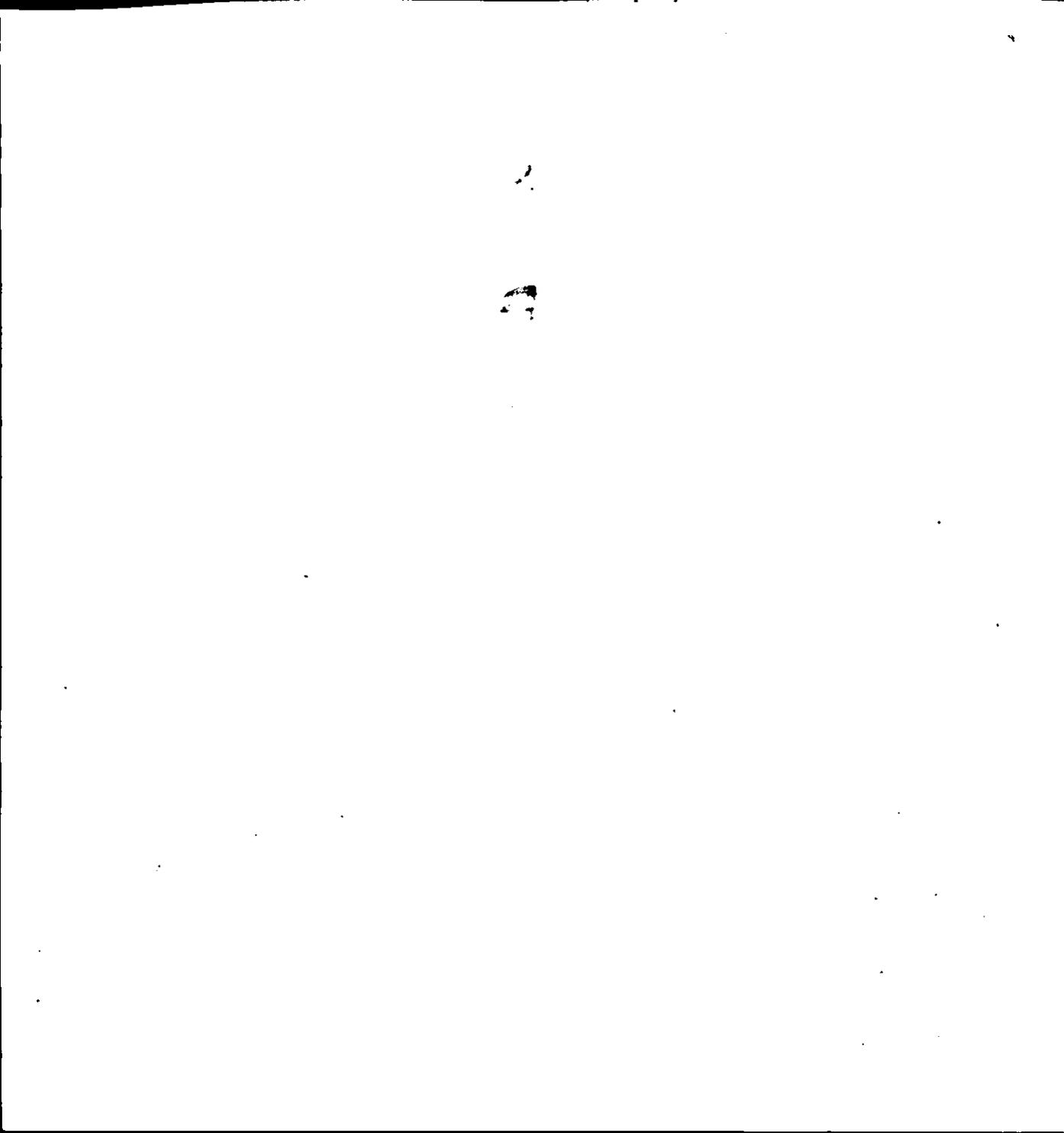
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physiologic
(Signed) G. H. Fitch M. D.

(Address) July 27 1930

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sharon Cem DATE OF BURIAL July 28 1930

20. UNDERTAKER B. Hays ADDRESS Dupel, Mo.



**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 Cass Registration District No. 15-1 File No.
Township Primary Registration District No. 4085- Registered No. 7
City Drexel (No.) St. Ward)

2. FULL NAME

Clarence 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 S (write the word)

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 (duration) yrs. mos. ds.
(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)

FILED July 28, 1930 John S. Bandy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

18. WHERE WAS DISEASE CONTRACTED Toxemia due to fall (duration) yrs. mos. ds.
This family was prominent and
left shortly after
the boy died
address unknown

IF NOT AT PLACE OF DEATH, DATE OF DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? 185

(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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

S-22229