

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

SEP 22 1930

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

Do not use this space.

25983

1. PLACE OF DEATH **85**
County **Buchanan** Registration District No. **1001**
Township Primary Registration District No. **1001**
City **St Joseph** (No. **3019 Locust Street**)

File No. _____
Registered No. **986**
St. _____ Ward _____

2. FULL NAME **Harry Glenn Miller**
(a) Residence. No. **3019 Locust Street** St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **18** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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 **Melvina Miller**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **February 20, 1897**
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
33 6 10

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

9. BIRTHPLACE (CITY OR TOWN) **Metcalf Co.**
(STATE OR COUNTRY) **Kentucky**

PARENTS
10. NAME OF FATHER **John Miller**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Metcalf Co.**
(STATE OR COUNTRY) **Kentucky**
12. MAIDEN NAME OF MOTHER **Maggie Edwards**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Metcalf Co.**
(STATE OR COUNTRY) **Kentucky**

14. INFORMANT **Mrs Melvina Miller**
(Address) **3019 Locust St. St Joseph Mo.**

15. FILED _____ 19 _____
John G. [Signature]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **August 30 19 30**
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. **im** alive on _____, 19____, and that death occurred, on the date stated above, at **9/30 A** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Preliminary I. B.
3/30 (duration) **not known** yrs. mos. ds.
CONTRIBUTORY IMMEDIATE CAUSE—**asphyxia**
(SECONDARY) **clashed only a few minutes**
profuse hemorrhage (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. **Don't know - claims was contacted in army**
DID AN OPERATION PRECEDE DEATH? **No.** DATE OF _____

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS **Clinical & consult**
(Signed) **[Signature]**, M. D.

Aug. 30, 19 30 (Address) **St Joseph**

*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 **Mount Auburn Cemetery** DATE OF BURIAL **Sept 1 19 30**

20. UNDERTAKER **H. C. Siederfaden** ADDRESS **1802 Union**

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