DEC 22 1930

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

Do not use this space.
35656

23
32

1. PLACE OF DEATH
County: Clinton
Township: Lathrop
City: ~~Lathrop~~ (No. ..... St. ..... Ward)
Registration District No.: 206
Primary Registration District No.: 2844a.
File No.:
Registered No.: 31

2. FULL NAME: Mabel Lee 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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 23 - 1900

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	11	15	

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

9. BIRTHPLACE (CITY OR TOWN): Mo.
(STATE OR COUNTRY): Country

PARENTS
10. NAME OF FATHER: Wm Thomas Miller
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Kansas
12. MAIDEN NAME OF MOTHER: Maudie McFreman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Kentucky

14. INFORMANT: W. M. Miller Jr.
(Address): Lathrop Mo

15. FILED Nov 8, 1930 J. C. Timson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 8 — 1930

I HEREBY CERTIFY, That I attended deceased from Nov. 7 — 1930, to Nov. 8 — 1930, that I last saw h. w. alive on Nov. 8 — 1930, and that death occurred, on the date stated above, at 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus
Coma
59 (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) F. F. Longfield M. D
11-9-, 1930 (Address) Lathrop 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: Converse. Mo
DATE OF BURIAL: 11-9 1930

20. UNDERTAKER: Lee Moss Crank
ADDRESS: Lathrop, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Give full name of employer, if employed by a firm or corporation. Give full name of parents, if known. Give full name of informant, if not the person who filed the certificate.