

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

Do not use this space.

**30333**

**1. PLACE OF DEATH**

County Texas  
Township Cass  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 865  
Primary Registration District No. 6163

File No. \_\_\_\_\_  
Registered No. 17  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mark Miller

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

Length of residence in city or town where death occurred 61 yrs. 6 mos. 1 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 Widowed (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14 1852

7. AGE YEARS 79 MONTHS 2 DAYS 28 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Jan 1930 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Meade Co. Tenn

MOTHER 13. NAME Wright Miller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT James F Miller (ADDRESS) Cabard Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Miller DATE 8-12 1931

19. UNDERTAKER Rayford W. Elliott (ADDRESS) Cabard Mo.

20. FILED Aug 12, 1931 P. D. Subbard Registrar.

**3 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-12, 1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1931, to Aug 12, 1931

I last saw him alive on Aug 8, 1931. Death is said to have occurred on the date stated above, at 12 am.

The principal cause of death and related causes of importance were as follows:

Senility aggravated by fractured hip due to fall 6 mo ago. 1866

Date of onset Mar 1 1931

Other contributory causes of importance: 1943 162

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

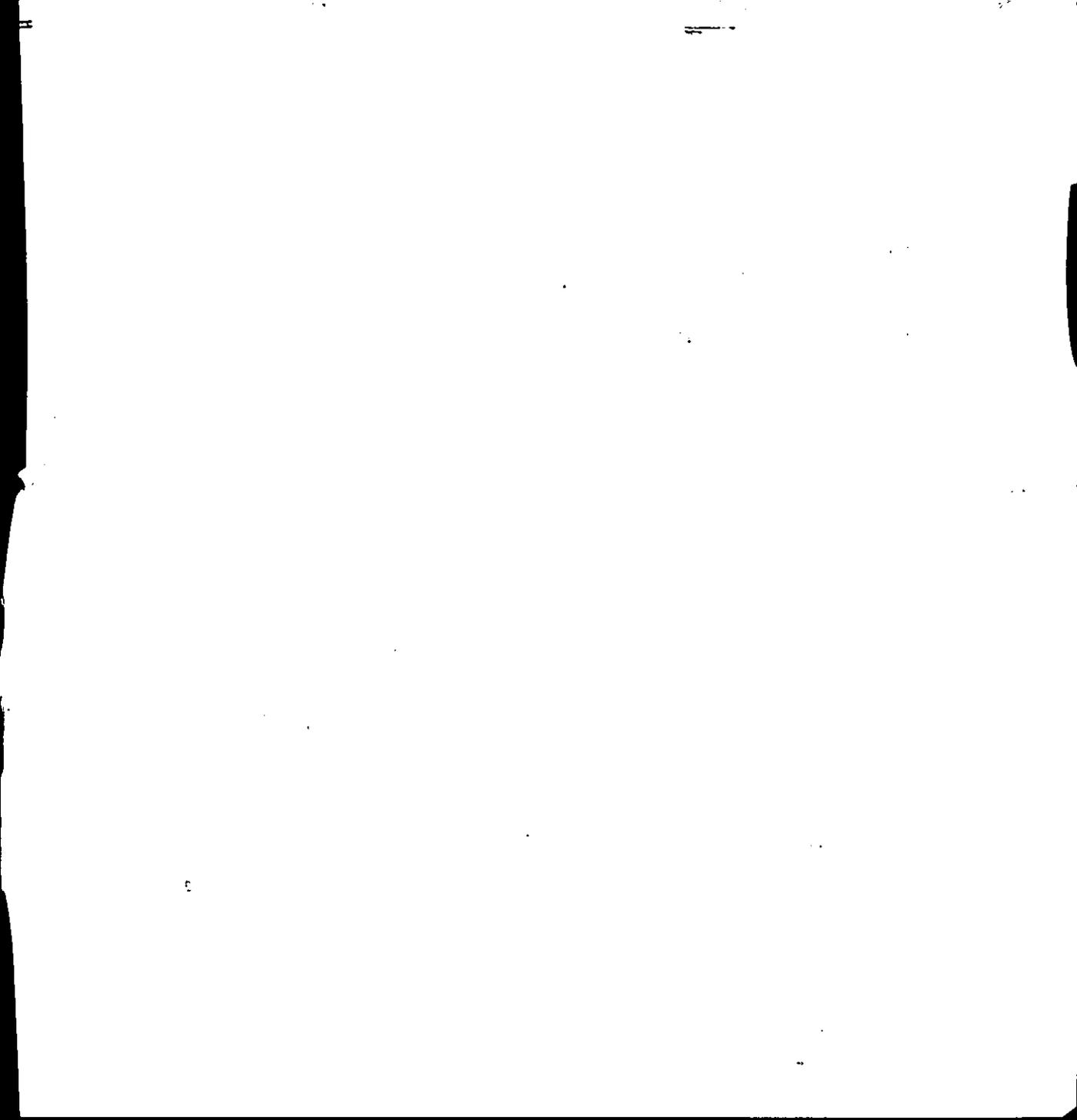
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_ Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no If so, specify \_\_\_\_\_

(Signed) Dr. James Elliott, M. D. (Address) Cabard Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Texas Registration District No. 865- File No. \_\_\_\_\_  
 Township Cass Primary Registration District No. 6143 Registered No. 17  
 City \_\_\_\_\_ (No. \_\_\_\_\_) Ward \_\_\_\_\_

**2. FULL NAME** Mark 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) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (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 \_\_\_\_\_  
 (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. File # Ab 12. 1931 R. O. Hubbard REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 19 31

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

*Violently aggravated X fracture of hip due to fall 6 months ago. fall at home out in the yard going to spring after water*

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) 1860 \_\_\_\_\_, M. D.  
 \_\_\_\_\_ (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

CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

REGISTRARS SHALL NOT RECEIVE A

SUPPLEMENTARY

S-30333