DEC 21 1937

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

Do not use this space.

1. PLACE OF DEATH
County Marion — Registration District No. 547 — File No. 41841
Township Mason — Primary Registration District No. 3079 — Registered No. 321
City Hannibal (No. 409 Fulton ave St. 4th Ward)

2. FULL NAME Louisa A. Miller
(a) Residence, No. 409 Fulton Ave St., 4th 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 26, 1868

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
69	3	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
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)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

FATHER
13. NAME Unk
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) " "

MOTHER
15. MAIDEN NAME "
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) "

17. INFORMANT (ADDRESS) Mrs Virgil Perkins 409 Fulton ave

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Mt Olive Cem DATE 10/30 1937

19. UNDERTAKER (ADDRESS) Jas O'Donnell Hannibal Mo

20. FILED Nov 1 1937 N C Fisher Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/26, 1937

22. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1937, to Oct 26, 1937
I last saw her alive on Oct 26, 1937 Death is said to have occurred on the date stated above, at 8 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Apoplexy	Oct 20

Other contributory causes of importance: Nephritis

Name of operation ..... 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) A L Shanks, M. D.
(Address) Hannibal Mo

132a

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

41841
Do not use this space.

. PLACE OF DEATH
(a) County Marion
(b) Township
(c) City Hannibal
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 547
Primary Registration District No. 3029
Registered No.

. PRINT FULL NAME Louisa A. Miller
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city)
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Wid

. MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	69	3	1	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

2. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No data
15. MAIDEN NAME No data
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No data

. INFORMANT (ADDRESS)

. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

. FUNERAL DIRECTOR (ADDRESS)

FILED Aug 8 1938 E. M. Ludee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 / 2 1937

22. I HEREBY CERTIFY, That I attended deceased from ..... 19.... to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

Apoplexy 131

Date of onset

Other contributory causes of importance:
Chronic Nephritis

Name of operation ..... 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? .....
If so, specify .....
(Signed) A. L. Shaufis, M. D.
(Address) Hannibal Mo

SUPPLEMENTARY