

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.

A. Knabb

6800

Do not use this space.

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

REC'D MAR 17 1938

1. PLACE OF DEATH *Greene*

(a) County *Greene* Registration District No. *318*

(b) Township *Springfield* Primary Registration District No. *2091 Dale*

(c) City *Springfield* (d) Street No. *911 E. Dale* (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.

2. PRINT FULL NAME *JOHN F. MILLER*

(a) Residence, No. *911 E. Dale* St. (If nonresident, give city or town and State)

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 *ELLA MILLER*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sep 11-1867*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<input checked="" type="checkbox"/>	<i>70</i>	<i>5</i>	<i>9</i>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Carpenter*

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

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) *Mo.*

FATHER

13. NAME *Jasper Miller*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER

15. MAIDEN NAME *Mary Margaret Selph*

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

17. INFORMANT (ADDRESS) *Ella Miller Springfield, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Timber Ridge Feb 22 38*

19. FUNERAL DIRECTOR (ADDRESS) *Wm. H. Hingray Co Springfield, Mo.*

20. FILED *Feb 21 1938* *Chas. H. George Local Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 20 1938*

22. I HEREBY CERTIFY, That I attended deceased from *Feb. 6 1938*, to *Feb 20 1938*

I last saw him alive on *Feb. 20 1938* Death is said to have occurred on the date stated above, at *20* m.

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

Date of onset

Meningitis acute non-specific 3 days

Influenza 2 wks

Otitis media acute 10 days

Other contributory causes of importance:

Name of operation *-* Date of *-*

What test confirmed diagnosis? *clinical* Was there an autopsy? *No*

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) *Arthur Knabb* M. D.

(Address) *450 1/2 E. Laurel St*

STATEMENT BY LICENSED EMBALMER

I, J. B. Klugner, Licensed Embalmer No. 3358
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Ray G. Crown
1763 L. E. Warren J. Hoblett
No. 4005 or by Wm. Max Rhodes, Registered Apprentice No. 117
working under my personal supervision.

Signed J. B. Klugner
Licensed Embalmer No. 3358

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)