

REC'D AUG 22 1938

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

Do not use this space.

25053

1. PLACE OF DEATH

County Clatsop
Township Washington
City Wyaconda (No. _____)

Registration District No. 194
Primary Registration District No. 4714

File No. _____
Registered No. 11
St. _____ Ward _____

2. FULL NAME William Obadiah Miller

(a) Residence, No. Wyaconda, Mo. 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. 7 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 Olive Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 22, 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 9 24

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

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) Virginia

FATHER 13. NAME William Miller

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

MOTHER 15. MAIDEN NAME Mary Belcher

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

17. INFORMANT Mrs Olive Miller (ADDRESS) Wyaconda mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Des Moines, Ia. DATE July 18 1938

19. UNDERTAKER Gerth & Baskett (ADDRESS) Wyaconda, Mo.

20. FILED July 18, 1938 Cassie Blattner Registrar (Address) Wyaconda Mo

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16, 1938

22. I HEREBY CERTIFY, that I attended deceased from June 28, 1938, to July 16, 1938

I last saw him alive on July 16, 1938. Death is said to have occurred on the date stated above, at 12:30 a.m.

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

Pneumonia Date of onset Do not know

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) Don Price, M. D.

(Address) Wyaconda Mo

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County Clare Registration District No. 194
 (b) Township _____ Primary Registration District No. 4114 Registered No. 11
 (c) City Nyalaonda (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.

2. PRINT FULL NAME William Obadiak Miller

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 9 24

OCCUPATION
 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

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

FATHER
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15, 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19__ to _____, 19__

I last saw him alive in July 15, 1938. 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:

Prostration
10/16
 Other contributory causes of importance:

Date of onset

do not know

Name of operation _____ Date of _____
 What test confirmed diagnosis? phy. exam as 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?

If so, specify _____ (Signed) A. E. Pierce, M. D.
 (Address) Nyalaonda Mo

SUPPLEMENT

REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

DON PIERCE, M. D.

Wyaconda, ~~Mo.~~ Missouri

Sept. 22nd. 1938.

Sirs;

I did not see this patient (Mr. Miller) until July 10th. he had an Osteo-
path here before that, and they took him to the hospital on July 15th.
He was sick when I first saw him and died in Keokuk at the hospital.
I do not know when his last sickness started nor at what time he died.

Yours resp.

Don Pierce

Don Pierce, M.D.