

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.

RECORDED FEB 6 1939

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

4026
 Do not use this space.

1. PLACE OF DEATH

(a) County Scott Registration District No. 816
 (b) Township _____ Primary Registration District No. 4492 Registered No. 24
 (c) City Chaffee (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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

460 Thomas Frederick Miller
 (a) Residence, No. 127 Helen Ave 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 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 Julia Ann Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 8, 1841

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>96</u>	<u>8</u>	<u>28</u>	

OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	<u>Farmer</u>
	9. Industry or business in which work was done, as saw mill, bank, etc.	<u>Retired</u>
	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) Wardin Co Ky

FATHER 13. NAME William Coffey Miller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

MOTHER 15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT (ADDRESS) Mrs T F Miller Chaffee, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Ward Farm Cem. Chaffee Mo DATE 1/9/1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bishop Hoff & Hobbs Chaffee Mo

20. FILED 19 1939 W. O. Finnen Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 6 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 2nd 1939, to Jan 5th 1939
 I last saw him alive on Jan 1st 1939. Death is said to have occurred on the date stated above, at 8 a.m.
 The principal cause of death and related causes of importance were as follows:

Chronic cystitis
Chronic bronchitis?
Nephritis
 Other contributory causes of importance: Senility

Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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) W. O. Finnen M. D.
 (Address) Chaffee, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Mamie Bingham Jeff

or by

Registered Apprentice No., working under my personal supervision.

Signed *Mamie Bingham Jeff*

Licensed Embalmer No. *3242*

P. O. Address *Chaffee Ms*

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.)

If this body is not embalmed, above space should be left blank.