

GOOD MAR 17 1939

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

6623  
Do not use this space.

1. PLACE OF DEATH

(a) County Harrison Registration District No. 1012  
(b) Township Butler Primary Registration District No. 5480 Registered No. 1  
(c) City ..... (d) Street No. ....  
(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

(a) Residence, No. 4611 William Madison Miller St.  County County  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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 - Victoria Miller (OR) WIFE OF  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 25 1855  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
83 7 9

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 4 1939  
22. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1938, to Feb 4, 1939  
I last saw him alive on Feb 1, 1939. Death is said to have occurred on the date stated above, at 4:30 a.m.  
The principal cause of death and related causes were as follows:

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

Arthritis with delirium  
Heart Lesion  
Date of onset  
Other contributory causes of importance: 92W

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

FATHER  
13. NAME Robert Miller

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

MOTHER  
15. MAIDEN NAME Sarah Talbert

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

17. INFORMANT (ADDRESS) Clyde Miller  
McCall Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE White Oak DATE Feb 5 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. S. Noble  
New Hampton Mo

20. FILED Feb 2 1939 Mr Woodson Reed Local Registrar

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) E. B. Poles, M. D.  
(Address) New Hampton Mo

RECEIVED

District Health Officer No. 111

District File Number 39-80

Date Filed MAR 9 1939

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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, .....

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed W. H. Noble

Licensed Embalmer No. 2904

P. O. Address W. H. Noble

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.