WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

88
6
3

LEG'D APR 25 1939

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

12020
Do not use this space.

1. PLACE OF DEATH
(a) County Randolph 2 Registration District No. 735
(b) Township 1 Primary Registration District No. 3034 Registered No. 52
(c) City Moberly (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 460 Artemesia Miller
(a) Residence, No. 1021 Franklin 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

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Andrew Jackson Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Mar 9-1856

7. AGE: YEARS 81 | MONTHS 11 | DAYS 25 | If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: House Keeper
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): Ill 1

FATHER
13. NAME: George K Reed 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Pa 4

MOTHER
15. MAIDEN NAME: Mary Foster
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Eng.

17. INFORMANT (ADDRESS): Mrs. Jimmie Barton Moberly

18. BURIAL, CREMATION, OR REMOVAL
PLACE Clarence Mo DATE 3-5-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): E E Hopper Clarence Mo

20. FILED Mar. 5 1939 Leah Williams
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Mar 3, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 23, 1939, to Mar. 3, 1939
I last saw her alive on Mar 2, 1939 Death is said to have occurred on the date stated above, at 2:00 a.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Bronchial Pneumonia | Feb 25 1939 |

Other contributory causes of importance: 107a
Hypertension

Name of operation: None 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) Martin P. Hunter, M. D.
9.25 (Address) Moberly, Mo.

Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-39-707
Date Filed APR 17 1939

**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 E E Hoffman

Licensed Embalmer No. 878

P. O. Address Delaware Ohio

**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.**