

28986

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

REC'D SEP 15 1939

Registration District No. 231

Primary Registration District No. 5314

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Merriwell, Missouri  
(c) Name of hospital or institution: Merriwell  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1  
(c) City or town Merriwell (If outside city or town limits, write "RURAL")  
(d) Street No. Home (If rural, give location)  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Mary Mc Miller

3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased (Month) 2 (Day) 7 (Year) 1899

8. AGE: Years 80 Months 6 Days 20 If less than one day hr. min.

9. Birthplace Marion, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name Randy Mc Miller

13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name Isabel Mason

15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Paulin Shelton  
(b) Address Shelville, Missouri

17. (a) Burial (b) Date thereof 8/23-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marion Cemetery

18. (a) Signature of funeral director L. J. Jones  
(b) Address Shelville, Missouri

19. (a) 9-8-39 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 21<sup>st</sup>  
year 1939 hour 6 minute 0 P. M.

21. I hereby certify that I attended the deceased from Sep 1937 to Aug 21 1939; that I last saw him alive on Aug 14 1937; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to 82W

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None  
Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Shelville, Mo Date signed 8-21-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE 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.

Rev. 5-17-39  
U.S. GPO: 1939 O-118511

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

*L. J. Jones*

Registered Apprentice No.

working under my personal supervision.

District Health Officer No. 5,

District File Number 939 208

Date Filed 9/13/39

Signed

*L. J. Jones*

Licensed Embalmer No.

2379

P. O. Address

Steelville Mo

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.