REC'D OCT 1 5 1939

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

31726
Do not use this space.

1. PLACE OF DEATH

(a) County Adair — Registration District No. 2

(b) Township — Primary Registration District No. 5002 — Registered No. 215

(c) or City Novinger R.F.D. — (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 65 yrs. 8 mos. 16 ds. — (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Marion C. Miller

(a) Residence, No. Novinger R.F.D. 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: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 12-19-1873

7. AGE: YEARS 65 — MONTHS 8 — DAYS 16 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.: Farm
10. Date deceased last worked at this occupation (month and year): March 1939
11. Total time (years) spent in this occupation: Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Novinger Missouri

FATHER
13. NAME: John D. Miller
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

MOTHER
15. MAIDEN NAME: Louise Schuele
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Bethel Missouri

17. INFORMANT (ADDRESS): Scilvia M. Miller Novinger Mo. R.F.D.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE: Novinger Cem't — DATE: Sept. 6 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Dee Riley Kirksville Mo.

20. FILED: Sept 20 1939 Spencer L. Freeman
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Sept. 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 2d, 1939, to Sept 4th, 1939
I last saw him alive on Sept 4th, 1939. Death is said to have occurred on the date stated above, at 2:45 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Undulant Fever	

Other contributory causes of importance:
Lung abscess - Myocarditis and Nephritis (diffuse)

Name of operation: none — Date of: —
What test confirmed diagnosis? clinical & lab. — 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? —
If so, specify probably from milk or working with cattle
(Signed) Geo. F. Snyder, M. D.
(Address) Kirksville Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

I X16605

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RECEIVED
District Health Officer No. 10
District File Number 10-39-1791
Date Filed OCT 10 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.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

31726 X
Do not use this space.

1. PLACE OF DEATH
(a) County Adair — Registration District No. 2
(b) Township Ninevah — Primary Registration District No. 2002 — Registered No.
(c) City — (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 Marion C. Miller
(a) Residence, No. — 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: 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 65 — MONTHS 8 — DAYS 16 — If LESS than 1 day, ...hrs. or ....min.

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 Nov. 6, 1939 Spencer L. Freeman
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-5-, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19.....
I last saw h..... alive on ....., 19..... 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:

	Date of onset
Undulant Fever	

Other contributory causes of importance:
Lung abscess Myocarditis and Nephritis (Diffuse) (Chronic)

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?
If so, specify
(Signed) Geo. T. Sneed, M. D.
(Address) Kirksville Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED.