

1939 OCT 12 1939

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

32347
Do not use this space.

1. PLACE OF DEATH

(a) County Fresenius? Registration District No. 214
(b) Township Central Primary Registration District No. 4178
(c) City St. Clair
(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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

George Daniel Miller
(a) Residence, No. _____ 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 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 Maggie Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 24, 1959

7. AGE YEARS 87 MONTHS 6 DAYS 8 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.
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) Livingston 2d.

FATHER 13. NAME George Miller

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

MOTHER 15. MAIDEN NAME Elizabeth Miller

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

17. INFORMANT (ADDRESS) Mrs. George Miller
St. Clair Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Int. Home DATE Oct. 4 '39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Casper & Lenox
St. Clair Mo.

20. FILED 11-8 1939 M. N. Duckworth
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-2-1939

22. I HEREBY CERTIFY, That I attended deceased from 2-6-1939 to 10-2-1939

I last saw him alive on 9-26-1939 Death is said to have occurred on the date stated above, at 10A m.
The principal cause of death and related causes of importance were as follows:

Tuberculosis of lungs
Date of onset _____

Other contributory causes of importance: 22

Name of operation no 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 W. E. Mitchell, M. D.
(Signed) _____

(Address) St. Clair Mo.

of info. should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state
 CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 H. M. Leroy
Licensed Embalmer No. 3601
P. O. Address St. Clair

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)

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

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