

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

50M-7-20-57

I X12004

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.

NOV 14 1939

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

34981
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Jean Primary Registration District No. 1002 Registered No. 3956
 (c) City J. C. Mo. (d) Street No. General Hospital #2 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 Henry Miller
 (a) Residence, No. 1618 Virginia 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unk.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-25-1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>57</u>	<u>9</u>	<u>15</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

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) Kentucky

13. NAME Deceased Sam Miller

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

15. MAIDEN NAME Deceased (unknown)

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

17. INFORMANT (ADDRESS) Record Clerk General Hosp #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE 10-14 1939

19. FUNERAL DIRECTOR (ADDRESS) Adkins Bros. 2000 E. 12th K.C. Mo.

20. FILED 10/14 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 6-9 1939, to 10-10 1939
 I last saw him alive on 10-10 1939 Death is said to have occurred on the date stated above, at 1:45 P.M.
 The principal cause of death and related causes of importance were as follows:
Decubitus Ulcer & Toxemia
 Date of onset _____

Other contributory causes of importance: 153

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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 _____
 (Signed) G. A. Turner M. D.
 (Address) General Hospital #2

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Edw. G. Evans

Licensed Embalmer No.

3836

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.)