

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

35761
Do not use this space.

1. PLACE OF DEATH *Cass 2*
 (a) County *Cass* Registration District No. *156*
 (b) Township *Peccan* Primary Registration District No. *5220*
 (c) City _____ or _____ (d) Street No. _____ Registered No. *57*
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 *H. O. Eric. B. 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *J. Frank Miller*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 23-1879*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
60 30 2
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Homemaker*
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 23 1939*
 22. I HEREBY CERTIFY, That I attended deceased from *Oct 15 1939* to *Oct 23 1939*
 I last saw her alive on *Oct 22 1939*. Death is said to have occurred on the date stated above, at *7A* m.
 The principal cause of death and related causes of importance were as follows:
Causes of Frontal Sinus
 Date of onset _____
 Other contributory causes of importance: *578*
 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) *J. A. Heath*, M. D.
 (Address) *Harrisonville, Mo*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*
 FATHER 13. NAME *Daniel B. Neff*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*
 MOTHER 15. MAIDEN NAME *Nancy Ellen Wiley*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*
 17. INFORMANT (ADDRESS) *J. F. Miller Peccan, Mo. R. 2*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Crest* DATE *10/25 1939*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **RUNNENBURGER'S HARRISONVILLE, MO.**
 20. FILED *Oct 29 1939* *Peccan, Mo.* Local Registrar.

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.

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 Ernest Rannenburg

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.