

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35783

Registration District No. 175

Primary Registration District No. 5246

Registrar's No. 39

1. PLACE OF DEATH: Chariton (1550 NOV 7)  
(a) County Chariton  
(b) City or town Ween  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Chariton  
(c) City or town Ween  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 70 years years

In this community \_\_\_\_\_  
years, months or days)  
3. (a) PRINT FULL NAME Joseph Miller  
8. (b) If veteran, \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_  
name was \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 12  
year 1939 hour 7:30 minute a. M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Anna K. Kloster 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased Nov 11 1860  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 6th 1938, to Oct 12 1939  
that I last saw him alive on Oct 12 1939  
and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 11 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Berlin Germany  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Immediate cause of death Chronic Myocarditis Duration 6mo  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Major findings: Nurse  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically

MOTHER FATHER { 12. Name Theodore Miller  
13. Birthplace Berlin Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Bertrude Braut  
15. Birthplace Berlin Germany  
(City, town, or county) (State or foreign country)  
16. (a) Informant's own signature Dorothy Miller  
(b) Address Ween MO  
17. (a) Rural (b) Date thereof Oct 14 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St Mary's  
18. (a) Signature of funeral director James M. ...  
(b) Address Marion MO  
19. (a) 10/13/39 (b) ...  
(Date received local registrar) (Registrar's signature)

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?  
(Specify type of place)  
While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
23. Signature ... (M. D. or other) \_\_\_\_\_  
Address New ... MO Date signed Oct 14 39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARGIN RESERVED FOR BINDING  
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.

RECEIVED  
District Health Officer No. 8,  
No. 11/6/38  
No. 11/6/38

**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..... Dale Bunch  
Licensed Embalmer No. 4088  
P. O. Address Marceline 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.**