

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. 241

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City

(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hrs.
(Specify whether _____)

In this community infant
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cole

(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")

(d) Street No. 720 E High St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Baby Miller 460

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced infant

6. (b) Name of husband or wife _____

6. (c) Age of husband for wife if alive _____ years

7. Birth date of deceased Oct 14 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____

12 hr. _____ min.

9. Birthplace Jefferson City Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Claude Miller

15. Birthplace Unknown

16. (a) Informant's own signature Claude Miller

(b) Address 720 E High St.

17. (a) Burial (b) Date thereof Oct 16-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cem.

18. (a) Signature of funeral director Frances Funeral Home

(b) Address Jefferson City, Mo. 64501

19. (a) 10/17/39 (b) L. B. Jones M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 15 day October
year 1939 hour _____ minute 39 M.

21. I hereby certify that I attended the deceased from Oct 14, 1939, to Oct 15, 1939; that I last saw him alive on Oct 15, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to (Pneumonia) Myocarditis

Due to fracture both

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

Duration 1 day

PHYSICIAN _____

Underline the cause to which death should be charged statistically

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) _____ (e) Means of injury _____

23. Signature MR Adredon (M. D. or other) _____

Address Jefferson City Mo Date signed 10/17/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Victor Buescher

Licensed Embalmer No. 3701

P. O. Address J. C. No.

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.