

NOV 24 1939

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

36518  
Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 470  
(b) Township North Mt Vernon Primary Registration District No. 5633 Registered No. 149  
(c) City Mt. Vernon (d) Street No. Missouri State Sanatorium 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 2 yrs. 9 mos. 10 ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Helen Eva Miller  
(a) Residence, No. Clinton, Mt Vernon Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF W. W. Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 15, 1895

7. AGE YEARS 51 MONTHS 10 DAYS 19 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as saw mill, bank, etc. X  
10. Date deceased last worked at this occupation (month and year) 1930 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton Kentucky

FATHER 13. NAME Edw. E. Hodge

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton Kentucky

MOTHER 15. MAIDEN NAME Emma Hayes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hickman Kentucky

17. INFORMANT E. McMichael, Record Clerk  
(ADDRESS) Missouri State Sanatorium

18. BURIAL, CREMATION, OR REMOVAL PLACE Clinton Mo DATE 10/4/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leo B. Orr Mt Vernon

20. FILED Oct 4 1939 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 4, 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1936 to Oct. 4, 1939

I last saw her alive on Oct. 4, 1939 Death is said to have occurred on the date stated above, at 8:45a.m.

The principal cause of death and related causes of importance were as follows:

Pneumonia  
Tuberculosis  
Date of onset 1929

Other contributory causes of importance: 23

Name of operation None Date of Mo

What test confirmed diagnosis 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) Chas. J. Greener, M.D.  
Mo (Address) Mt Vernon

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.

MARGIN RESERVED FOR BINDING

V. S. NO. 1 X 16803  
80M-9-19-38

RECEIVED

District Health Officer No. 6,

District File Number 1639-2188

Date Filed NOV 7 1939

11200  
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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

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

50M-8-1007 I X12241

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36518  
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1. PLACE OF DEATH

(a) County Lawrence Registration District No. 470  
 (b) Township N. Mt Vernon Primary Registration District No. 3633 Registered No. 142  
 (c) City..... (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Eva 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF.....  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
31 10 19  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....  
 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Oct 4 1939 P. A. Holmes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 4 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m. The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

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) Chester J. Mellie, M. D.

(Address) Mt Vernon

