

DEC 11 1939

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

39001  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 85  
 (b) Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 1130  
 or St. Joseph  
 (c) City \_\_\_\_\_ (d) Street No. 1904 Washington Avenue \_\_\_\_\_ 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 76 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ernest William Miller  
 (a) Residence, No. 1904 Washington Avenue 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 white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 24, 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
	<u>79</u>	<u>0</u>	<u>7</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Clerk  
 9. Industry or business in which work was done, as saw mill, bank, etc. Railroad office  
 10. Date deceased last worked at this occupation (month and year) 1927 11. Total time (years) spent in this occupation. 35

MOTHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sabetha, Kansas

FATHER

13. NAME Edwin Miller,  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, New York.

15. MAIDEN NAME Fannie Graham,  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartford, Connecticut.

17. INFORMANT Mrs. Elmina Miller  
 (ADDRESS) 1904 Washington Avenue, St. Joseph

18. BURIAL, CREMATION, OR REMOVAL St. Joseph, Missouri  
 PLACE Green Cemetery, DATE November 3, 1939

19. FUNERAL DIRECTOR (NAME) Walter Meierhoffer  
 (ADDRESS) 1302 Faraon St., St. Joseph

20. FILED Nov. 3, 1939 A. J. Keathley  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-25, 1939, to 11-1, 1939  
 I last saw him alive on 11-1, 1939 Death is said to have occurred on the date stated above, at 10:57 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Coronary occlusion  
 Date of onset 10.4.39

Other contributory causes of importance:  
Senility  
Comp. acidosis  
pneumonia  
 Date of 10-25-39

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) Thomas Redmond, M. D.  
 (Address) Kirkpatrick Building, St. Joseph

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. N. 2.  
50M-9-19-38  
I X1645

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.

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State Board  
of Health

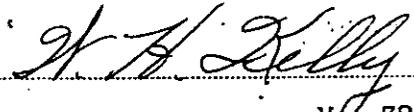
**STATEMENT BY LICENSED EMBALMER**

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. 3946

P. O. Address St. Joseph, Missouri

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Tuchanan Registration District No. 85-  
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 1130  
(c) City St Joseph (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 Ernest William Miller

(a) Residence, No. \_\_\_\_\_ 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

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

7. AGE YEARS 79 MONTHS 0 DAYS 7 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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) \_\_\_\_\_

13. NAME

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

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 Nov 3 1939 J. Neelbuck

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 1 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19 \_\_\_\_\_

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:

Coronary Occlusion Date of onset 10-24-39  
94 b  
Other contributory cause of importance:  
Genital  
Coma acidosis 10-28-39  
Pneumonia Bronchial 10-28-39

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) Thomas Redmond, M. D.  
(Address) St Joseph, Mo.

SUPPLEMENTARY

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

