

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 214

Registration District No. 796

Primary Registration District No. 3038

1. PLACE OF DEATH

(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbon's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 11 1/2 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. Russell St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Lillie Belle Miller

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife W. H. Miller 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased June 16 1874
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Martin Cress

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Bell

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joe W. Cress
(b) Address Staten Mo.

17. (a) Burial (b) Date thereof Dec 31-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Cress

18. (a) Signature of funeral director Comptrol-Dein
(b) Address Marshall, Mo.

19. (a) 12-31-39 (b) Mary Kent
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1939 hour 11 minute 10.00 M.

21. I hereby certify that I attended the deceased from Dec 20 to Dec 29, 1939
that I last saw her alive on Dec 29, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma Duration 12 hrs
Due to Diabetic Mellitus 3 yrs.

Due to _____
Other conditions Arterial Sclerosis 3 yrs.
(Include pregnancy within 3 months of death)

Major findings: ✓ 8 1/2
Of operations _____
Of autopsy W

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Marshall Date signed 12/29/39

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

Rev. 5-17-39
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,
District File Number 112/40
Date Filed

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.....

P.W. Campbell....., Registered Apprentice No.....
working under my personal supervision.

Signed P.W. Campbell.....

Licensed Embalmer No. 3469.....

P. O. Address Marshall, 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.