

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2430

102

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. _____

1. PLACE OF DEATH

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution 2244 N. Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 11.20

3. (a) PRINT FULL NAME John Watson Miles
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 29, 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 81 0 1 hr. min.

9. Birthplace Mauwelle Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Employee
11. Industry or business Packing House Emp.

MOTHER FATHER
12. Name James Miles
13. Birthplace England
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's name John Watson Miles
(b) Address 2244 N. Main City

17. (a) Burial (b) Date thereof Feb. 1, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hayelwood

18. (a) Signature of funeral director Alvin Schmeizer
(b) Address Springfield, Mo.

19. (a) 2/1/40 (b) Chas. H. Berg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2244 N. Main
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Jan 27, 1940 to Jan 30, 1940
that I last saw him alive on Jan 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 3 days

Due to Influenza 191
Chronic reprints
Due to Drug 10 yrs

Other conditions Urinary Retention
(Include pregnancy within 3 months of death)
enlarged prostate

Major findings: Of operations, drops
Of autopsy no

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) no
(b) Date of occurrence _____
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

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

23. Signature J. F. Freyman (M. D. or other)
Address Springfield, Mo. Date signed 1-31-40

U. S. GOVERNMENT PRINTING OFFICE: 1935

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.

FEB 13 1940

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 Harlow Knabb

Licensed Embalmer No. 4065

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.

X