DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3950

FEB 15 1940

Registration District No. 801 Primary Registration District No. 6045 Registrar's No. 3

1. PLACE OF DEATH: (a) County Pettis 2 (b) City or town Rural Liberty Trush (If outside city or town limits, write "RURAL" and name of township) (c) Name of hospital or institution: (If not in hospital or institution, write street number or location) (d) Length of stay: In hospital or institution (Specify whether) In this community years, months or days) Life

2. USUAL RESIDENCE OF DECEASED: (a) State Mo (b) County Pettis (c) City or town Rural Liberty Trush (If outside city or town limits, write "RURAL") (d) Street No. (If rural, give location) (e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Lilly Jane Miller 46

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 Widow

6. (b) Name of husband or wife Francis M. Miller 6. (c) Age of husband or wife if alive Dead years

7. Birth date of deceased FEB. (Month) 12 (Day) 1857 (Year)

8. AGE: Years 80 Months 10 Days 26 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business at home

FATHER 12. Name Harvey Calvin

13. Birthplace Cooper Co Mo (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Rebecca Younger

15. Birthplace Cooper Co Mo (City, town, or county) (State or foreign country)

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

(b) Address Sweet Springs Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10-40 (Month) (Day) (Year)

(c) Place: burial or cremation Longwood Cemetery

18. (a) Signature of funeral director R C Carter

(b) Address Sweet Springs Mo

19. (a) Jan 8 (Date received local registrar) (b) Miss E. E. Reid (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8th year 1940 hour 2 00 minute P. M.

21. I hereby certify that I attended the deceased from Jan 7th, 1940, to Jan 8th, 1940, that I last saw h alive on Jan 8th, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Acidosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations

Of autopsy

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)

While at work? (e) Means of injury

936 23. Signature Chas R Parsons (M. D. or other) M.D.

Address Sweet Springs Date signed 1-9-40

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X19511

109

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4/4/40

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 R C Courter

Licensed Embalmer No. 3513

P. O. Address Tuscumbia, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
X22859

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3950

Registration District No. 801 — Primary Registration District No. 6045 — Registrar's No. 3

1. PLACE OF DEATH:
(a) County Salinas
(b) City or town Liberty (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Lucy Jane Miller
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 | Months 10 | Days 26 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Senility	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
While at work? (e) Means of injury

23. Signature Chas R. Parsons (M. D. or other)
Address Sweet Springs Mo. Date signed

SUPPLEMENTARY