

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.

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

6190
Do not use this space.

REC'D MAR 12 1940

1. PLACE OF DEATH *Cape Girardeau*
 (a) County *Cape Girardeau* Registration District No. *121*
 (b) Township *Cape Girardeau* Primary Registration District No. *3009*
 (c) City *Cape Girardeau* (d) Street No. *S.E. Mo. Hospital* Registered No. *69*
 (e) Length of residence in city or town where death occurred *460* yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 2. PRINT FULL NAME *Joseph M. Miller*
 (a) Residence, No. *Beauville, Mo.* St. Beauville, Mo.
 (Usual place of abode if no other 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) *Widower*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Martha E. Miller*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 8, 1861*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 4 11

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*
 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) *Bollinger Co., Mo.*

FATHER
 13. NAME *Geo. W. Miller*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *North Carolina*

MOTHER
 15. MAIDEN NAME *Lamer*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *North Carolina*

17. INFORMANT (ADDRESS) *W. W. Miller, Marble Hill, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Ann's* DATE *2-21-40*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Baker Funeral Home, Lantzville, Mo. S. E. Graham*

20. FILED *2-19-40* *J. M. Thompson* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 19, 1940*
 22. I HEREBY CERTIFY, That I attended deceased from *12/29, 1939, to 2/19, 1940*
 I last saw him alive on *2/19, 1940* Death is said to have occurred on the date stated above, at *6:15 P.M.*
 The principal cause of death and related causes of importance were as follows:
Intestinal Obstruction Date of onset *2-3-40*
 Other contributory causes of importance:
 Name of operation *Cydon Laparotomy* Date of *1/2-40*
 What test confirmed diagnosis? *Opac* 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*
 (Signed) *George E. Baker*, M. D.
 (Address) *Cape Girardeau, Mo.*

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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.....

mes....., Registered Apprentice No.....

working under my personal supervision.

Signed J. C. Graham.....

Licensed Embalmer No. 4010.....

P. O. Address Lutesville, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6190**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **125**

Primary Registration District No. **3009**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Cape Girardeau**

(b) City or town **Cape Girardeau**
(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)

3. (a) PRINT FULL NAME **Joseph M. Miller**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M**

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 _____ year

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

8. AGE: Years **78** Months **4** Days **11** If less than one day _____ h. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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.

20. DATE OF DEATH: Month **Feb** day **19** year **1980** hour _____ minute _____ M.

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

Immediate cause of death **Intestinal obstruction**

Due to **Intussusception - ileum non malignant.**

Due to **George H. Greer**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration _____

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 **G. H. Walker** (M. D. or other) _____

Address **Cape Girardeau** _____ Date signed _____

SUPPLEMENTAL REPORT

