

MISSOURI STATE BOARD OF HEALTH

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

18104
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 135
(b) Township 2 Primary Registration District No. 3010 Registered No. 59
(c) City Carrollton (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. 9 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

440 Gracie May Miller
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 6, 1940

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 0 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
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) 0

FATHER 13. NAME Chancey E Miller

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fort Dodge

MOTHER 15. MAIDEN NAME Mildred E Halberg

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) East St. Louis

17. INFORMANT (ADDRESS) Chancey E Miller
Carrollton Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACED St Marys DATE May 36, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley
Carrollton Mo

20. FILED 5/27 1940 John Haskins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 25, 1940

22. I HEREBY CERTIFY, That I attended deceased from May 24, 1940, to May 25, 1940
I last saw her alive on May 29, 1940 Death is said to have occurred on the date stated above, at 4:00 p.m.
The principal cause of death and related causes of importance were as follows:

Inability to
absorb food. 10
Date of onset

Other contributory causes of importance:
general weakness

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? No.

If so, specify _____

(Signed) R Hamilton Stanton M. D.

(Address) 130 Carrollton, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. INFORMATION should be carefully supplied.

RECEIVED
District Health Officer No. 8
District File Number 6-14-20
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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18104

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 135

Primary Registration District No. 3010

Registrar's No.

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits write "RURAL")
(d) Street No. E. Bolen Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. years.

3. (a) PRINT FULL NAME Gracie May Miller

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced
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 Months Days If less than one day
19 hr. min.

9. Birthplace Carrollton (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) 5-27-40 (b) Ruth Haskins (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 25 year 1940 hour minute M.

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

Immediate cause of death

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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 P. H. Stator (M. D. or other).....

Address Carrollton Mo. Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

