

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21619

State File No.

Registration District No. 1257 1940

Primary Registration District No. 5350

Registrar's No.

1. PLACE OF DEATH:

(a) County Daviess  
(b) City or town Grand River Township  
(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) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 1/2 yrs. (Specify whether)

3. (a) PRINT FULL NAME Albert Jefferson Miller  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 460

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Opal A. Miller 6. (c) Age of husband or wife if alive 40 years  
7. Birth date of deceased Jan 5, 1877  
(Month) (Day) (Year)

8. AGE: Years 63 Months 5 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Salesman

11. Industry or business \_\_\_\_\_

12. Name John H. Miller

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

14. Maiden name Mary Bland  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Opal A. Miller

(b) Address Jamesport, Mo. Route 1

17. (a) Burial (b) Date thereof June 5-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation General Cemetery

18. (a) Signature of funeral director Arner D. Soudon

(b) Address Chillicothe, Mo.

19. (a) 6/20/40 (b) W. A. Tug  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess  
(c) City or town Grand River Township  
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1940 hour 1 minute A.M.

21. I hereby certify that I attended the deceased from Saw him once on Mar. 20-1940, 1940; that I last saw him alive on Mar. 20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration about 4 months

1. History  
Due to sharp jerk of feet fell on his head & shoulder causing  
Due to Cerebral hemorrhage

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? 850

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

23. Signature W. A. Tug (M. D. brother)

Address Chillicothe, Mo. Date signed 6/15/40

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.

1941

RECEIVED

District Health Officer No. 11;

District File Number.....740-1117

Date Filed.....JUL 5 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.....

Donald B. Gordon

Registered Apprentice No. 223

working under my personal supervision.

Signed.....

James D. Gordon

Licensed Embalmer No. 1870

P. O. Address. Whitcomb, N

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. 21619

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 251

Primary Registration District No. 5350

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Daviess  
(b) City Franklin T.P.  
(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)

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 Albert Jefferson 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 m

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 63 Months 5 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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 Mrs. Opal B. Miller

(b) Address Garnesport, Mo.

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)

20. DATE OF DEATH Month June day 14 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 Cerebral Hemorrhage

History gave pain of head and shoulder causing cerebral hem-orrhage

Other conditions (Include pregnancy within 3 months of death) 1961 3

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence March 29, 1940

(c) Where did injury occur? Garnesport, Daviess Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? in corn cut on farm (Specify type of place) was cleaning up While at work? yes (e) Means of injury back fell

23. Signature C. M. Grace Address Chillicothe, Mo.

SUPPLEMENTAL COPY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

