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STANDARD CERTIFICATE OF DEATH

State File No. 31329

FILED OCT 11 1940

Registration District No. 50

Primary Registration District No. 3004

Registrar's No. 70

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

1. PLACE OF DEATH: Bates
 (a) County: Bates
 (b) City or town: Butler, Mo
 (c) Name of hospital or institution: Butler Memorial Hospital
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution 3 days
 (Specify whether
 In this community: 9 months
 years, months or days)

3. (a) PRINT FULL NAME: Thelma Pauline 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: married
 6. (b) Name of husband or wife: Chas. Harold Miller
 6. (c) Age of husband or wife if alive: 23 years
 7. Birth date of deceased: Mar 21 1922
 (Month) (Day) (Year)

8. AGE: Years 18 Months 5 Days 24
 If less than one day
 .hr. _____ min.

9. Birthplace: Amoret Bates Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation: housewife

11. Industry or business: Home

12. Name: Dr. J. H. Scroggins
 13. Birthplace: Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name: Thelma M. Westtown
 15. Birthplace: Richwood Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant: Chas. H. Miller
 (b) Address: Amoret, Mo

17. (a) burial (b) Date thereof: Sept 17, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Bryant's Cem.

18. (a) Signature of funeral director: Butler, Mo
 (b) Address: Butler, Mo 53

19. (a) Sept 17 1940 (b) Thelma L. Culver
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Mo (b) County: Bates
 (c) City or town: Amoret
 (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: Sept day: 15
 year: 1940 hour: 2 minute: 45 A.M.
 21. I hereby certify that I attended the deceased from Sept 12
 1940 to Sept 15 1940
 that I last saw her alive on Sept 15 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: _____
Cholera
 Due to: with Convulsions
 Due to: Acute Hemorrhagic Nephritis
 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?

(Specify type of place) _____
 While at work? _____ (Specify type of injury)
 23. Signature: Thos. A. Cook (M. D. or other) 11
Butler, Mo Date signed: 9/16/40
 Address: _____

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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, ~~and by~~.....

....., Registered Apprentice No.
working under my personal supervision.

Signed *D. Denton Lial*

Licensed Embalmer No. 4123

P. O. Address Butler, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31329**
Registrar's No. **70**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **50**

Primary Registration District No. **3004**

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

1. PLACE OF DEATH

(a) County **Butler mo**
(b) City or town **Butler mo**
(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 **Thelma Pauline 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 **m**

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 **18** Months **5** Days **24** 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 { 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 **Sept** day **15** 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 **Eclampsia with convulsions**
Due to **# 10 weeks of pregnancy N.M.D. #1**

Other conditions **acute Hemorrhagic nephritis # Due to pregnancy # 146**
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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

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

