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FILED NOV 25 1940

5926

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:

(a) County Platte
Weston Rural

(b) City or town _____
(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 alone 2
10 yr. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert K. Miller

3. (b) If veteran, name war:

3. (c) Social Security No.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: May 21 1877
(Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 0

If less than one day hr. _____ min. _____

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

10. Usual occupation Farm Labor

MOTHER FATHER

11. Industry or business _____

12. Name Stephen Miller

13. Birthplace not known
(City, town, or county) (State or foreign country)

14. Maiden name not known

15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Day Corbin

(b) Address Weston (Rural)

17. (a) Burial (b) Date thereof Oct 21 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rural Hill

18. (a) Signature of funeral director J H Boyle

(b) Address Weston Mo

19. (a) 10-20-40 (b) J H Boyle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Platte

(c) City or town Weston "Rural"
(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 October Day 21
year 1940 hour 12:30 minute P 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 Principally a Coronary Occlusion

Due to _____

Due to _____ 94 P.

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

Major findings: Of operations _____

Of autopsy No.

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? 628 (Specify type of place)

(g) Means of injury _____

23. Signature Leland H Francis (M.D. or other) _____

Address Parkville Mo Date signed Oct 21 40

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

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..... *J. H. Brill*

Licensed Embalmer No. *832*

P. O. Address *Wesley 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.