

No. 2
-13-40
17-39
X 23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38713

State File No. _____

FILED DEC 10 1940

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 920

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

1. PLACE OF DEATH:
 (a) County GREENE
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
890 1/2 N. Franklin
(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 Florence Miller
 3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 48 years
 7. Birth date of deceased December 7, 1931
(Month) (Day) (Year)

8. AGE: Years 8 Months 11 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation In school
 11. Industry or business 0

MOTHER FATHER
 12. Name Orville Miller
 13. Birthplace Webster County, Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Daynesport
 15. Birthplace St Joseph, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Orville Miller
 (b) Address 890 1/2 N. Franklin St.
 17. (a) Burial (b) Date thereof 11-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director Alma Johnson
 (b) Address Springfield, Mo.
 19. (a) 11-17-40 (b) W. E. Handley, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 890 1/2 N. Franklin
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov. day 15
 year 1940 hour 8 minute A. M.
 21. I hereby certify that I attended the deceased from August 23, 1940, to Nov. 15, 1940
 that I last saw her alive on Nov. 11, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease 3 yr
focal points injection probably toxic
 Due to _____
 Due to _____
 Other conditions 1 1/2
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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? _____ (b) Means of injury _____
 23. Signature W. Palang Danston, M.D. (M. D. or other) MD
 Address Springfield, Mo. Date signed 11/18/40

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.....

.....
working under my personal supervision.

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

Signed.....

Wayne Fickell

Licensed Embalmer No.....

34447

P. O. Address.....

Springfield

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.