

JAN 20 1941

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. 157

1. PLACE OF DEATH:

(a) County Laurence
(b) City or town mt Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days
In this community 15 days
years, months or days 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ripley
(c) City or town Danishman
(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 Clarence Alexander Miller

3. (b) If veteran, name war no 3. (c) Social Security No. 487-18-7831

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Flora Loren Miller 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Dec 5th 1901
(Month) (Day) (Year)

8. AGE: Years 39 Months 0 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Clerk

11. Industry or business Barber

12. Name Charles O Miller

13. Birthplace Sueden
(City, town, or county) (State or foreign country)

14. Maiden name Anna Anderson

15. Birthplace Pat mound Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Michael Reed Clerk
(b) Address Missouri State San -

17. (a) Removal (b) Date thereof Dec 15-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Danishman Mo
18. (a) Signature of funeral director J. S. Jackson (b) Address Danishman Mo
19. (a) 12-16-1940 (b) P.A. HOLMES 42
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15th year 1940 hour 11:55 minute am

21. I hereby certify that I attended the deceased from November 30th 1940 to Dec 15 1940
that I last saw him alive on Dec 15 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis
Subequent Pulmonary abt 13 mo.

Due to _____
Due to _____

Other conditions arteriosclerosis
(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) _____ X
(b) Date of occurrence _____ X
(c) Where did injury occur? _____ X
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ X

23. Signature J. S. Jackson (M. D. or other) _____
Address St. Vernon Date signed 12-15-40

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6,

District File Number 141-69

Date Filed JAN 9 1941

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.....

George B. Orr

Licensed Embalmer No.....

946

P. O. Address.....

2146 Remon St

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.