

No. 2
-1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 4 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27783

Registration District No. 44

Primary Registration District No. 5713

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Rocky Fork Burial Home
(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 Missouri (b) County Boone

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jesse Franklin Miller

3. (b) If veteran, name war _____ No. _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3rd
year 1941 hour 12 minute 20 M.

4. Sex Male 5. Color White (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 April 7 - 1863
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 3 1941 to 8-3- 1941
that I last saw him alive on July 29 1941
and that death occurred on the 3rd day and hour stated above.

Immediate cause of death: Arteriosclerosis Chronic Myocarditis Chronic Nephritis

8. AGE: Years 78 Months 3 Days 26 If less than one day _____ hr. _____ min.

Due to _____

Due to General Arteriosclerosis

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Robert Miller

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

14. Maiden name Anna Gray

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Tom Pugh

(b) Address Clinton mo 4-41

17. (a) Burial (b) Date thereof 8-4-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Drepping Springs

18. (a) Signature of funeral director Walter J. Fawcett

(b) Address Columbia mo

19. (a) 8-10-41 (b) W. J. Fawcett
(Date received local registrar) (Registrar's signature)

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

Major findings:
Of operations _____
Of autopsy _____

1312

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? _____ (Specify type of place) _____ (Means of injury)

23. Signature Walter J. Fawcett (M. D. or other) _____

Address Columbia Mo Date signed _____

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 *M. S. Mitsides*

Licensed Embalmer No. *3893*

P. O. Address *Calumet*

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.

Registration District No. 74

Primary Registration District No. 5113

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Rocky Ford 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)
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jessie Franklin Miller
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
10. DATE OF DEATH: Month _____ year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
that I last saw him/her alive on _____ 1941
and that death occurred on the date and hour stated above.
(Immediate cause of death) _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married divorced wid
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)

Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years _____ Months _____ Days _____ (If less than one day _____ 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 _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-4-41 (b) Mo J. L. Sauer
(Date received local registrar) (Registrar's signature)

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

S-27783