

Registration District No. 470

Primary Registration District No. 3633

1. PLACE OF DEATH:
 (a) County Lawrence
 (b) City or town Mt Vernon, Missouri
 (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 44 days
 (Specify whether _____)
 In this community 44 days
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Nodaway
 (c) City or town Maryville
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Byron Dunn Miller
 3. (b) If veteran, name war No
 3. (c) Social Security No. 496-07-9783

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day 22d
 year 1941 hour 3:55 minute A M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive X years
 7. Birth date of deceased Oct 26th 1879
 (Month) (Day) (Year)
 8. AGE: Years 61 Months 10 Days 28
 If less than one day _____ hr. _____ min.

21. I hereby certify that I attended the deceased from Aug. 12, 1941, to Sept. 22, 1941, and that death occurred on the date and hour stated above.
 Immediate cause of death _____
Pulmonary Tuberculosis
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

9. Birthplace Maryville Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Clerk
 11. Industry or business Unknown
 MOTHER FATHER { 12. Name John B. Miller
 13. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Fannie Miller
 15. Birthplace Unknown Unknown
 (City, town, or county) (State or foreign country)
 16. (a) Informant E. McMichael, Record Clerk
 (b) Address Missouri State Sanatorium
 17. (a) Removed (b) Date thereof 9 22 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Maryville Mo
 18. (a) Signature of funeral director W. Vernon Mo
 (b) Address _____
 19. (a) 9-22-1941 (b) _____
 (Date received local registrar) (Registrar's signature)

Duration _____
7 mo
 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) _____ (e) Means of injury _____
 23. Signature W. Vernon Mo (M. D. or other) Om D
 Address W. Vernon Mo Date signed 9/22/41

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

X26390

RECEIVED

District Health Officer No. 6,

District File Number 1041-1247

Date Filed OCT 6 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.....

Licensed Embalmer No. 946

P. O. Address 9th Avenue

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. 31927

Registration District No. 470

Primary Registration District No. 5633

Registrar's No.

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town mt. Vernon
(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 years, months or days)

In this community _____

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 Byron D. Miller

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 22 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; 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 w

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

7. Birth date of deceased Oct 26 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days _____
If less than one day hr. min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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) 9-22-1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

Other conditions _____
(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) _____

(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) (c) Means of injury

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

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941

S-31927