

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41797
Registrar's No. 53

FILED JAN -7 1942
Registration District No. 316

Primary Registration District No. 3061

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Flat River
(If outside city or town limits, write "RURAL" and name of township)
Name of hospital or institution: 1
(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 MARY E. MILLER
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex F 5. Color or race W 6. (a) Single, widowed, married, 2 divorced widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years
7. Birth date of deceased: 3 8 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 9 10 hr. min.

9. Birthplace Richlinton Ind
(City, town, or county) (State or foreign country)
10. Usual occupation House wife

11. Industry or business _____
MOTHER FATHER { 12. Name Chas - Bonser
13. Birthplace England 4
(City, town, or county) (State or foreign country)
14. Maiden name Anna Watts
15. Birthplace England 24
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Emmie Miller
(b) Address Flat River Mo
17. (a) Burial (b) Date thereof 13 21 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Marion Cemetery
18. (a) Signature of funeral director Caldwell Bras
(b) Address Flat River Mo
19. (a) Dec. 29-1942 (b) Byrdie Burkmaster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 94
(a) State Missouri (b) County St. Francois 5
(c) City or town Flat River
(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.? no 0 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 19
year 42 hour 3 minute 30 P. M.
21. I hereby certify that I attended the deceased from Jan 41 to Dec 19, 1942
that I last saw her alive on Dec 17, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo-pneumonia Duration 2 days
Due to _____ 107

Due to _____
Other conditions antitubercular reoperation
(Include pregnancy within 3 months of death)
arterio-sclerotic changes
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)
(a) Means of injury _____
23. Signature W. O. Kael (M. D. or other) 12/21/42
Address Flat River Date signed _____

istrict Health Officer No. 4
District File Number 143-13-53
Date Filed 1-6-43

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.....

P. O. Address.....

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.