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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18560

State File No.

FILED MAY 18 1942

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Nodaway
(b) City or town Marionville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Francis O
(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 Stanley Miller

3. (b) If veteran, name war..... 3. (c) Social Security No. 488-14-3908

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

6. (b) Name of husband or wife Carie Mae Miller 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Nov. 28 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 4 29 hr. min.

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

10. Usual occupation Laborer

11. Industry or business

12. Name Joseph Miller

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

14. Maiden name Isabel Jackson

15. Birthplace Warth County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Turn Miller

(b) Address 612 South Market Marionville Mo

17. (a) Burial (b) Date thereof 4-29-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Latta Grove North of Marionville Mo

18. (a) Signature of funeral director attendant Mrs Campbell Funeral Home

(b) Address 951 South Main Marionville Mo

19. (a) 4-29-43 (b) Mary Cole
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway
(c) City or town Marionville 874
(If outside city or town limits, write "RURAL")
(d) Street No. 612 South Market /
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 27
year 43 hour..... minute 8:45 PM

21. I hereby certify that I attended the deceased from 4-20 1943 to 4-27-43 1943
that I last saw him alive on 4-27-43 1943
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis
Cholerae
Arterio sclerosis

Duration

Due to.....

Due to.....

Other conditions 1318
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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 J. M. Boyler (M. D. or other)
Address Marionville Mo Date signed 4-29

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

MOTHER FATHER

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.....

W. Lean Campbell

Licensed Embalmer No. 2620

P. O. Address. Marysville, Y.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18560
Registrar's No. 61

Registration District No. 251 Primary Registration District No. 3048

WRITE IN INK -- USE UNFADING BLACK INK -- MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Wodaway

(b) City or town marionville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Francis
(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)

3. (a) PRINT FULL NAME Stanley miller

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

4. Sex m 5. Color or race W

6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Nov 28 1898
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 20 (If less than one day, min.)

9. Birthplace: Not available UNKNOWN
(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) _____ (b) Mary Coile
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1963 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 _____

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) _____

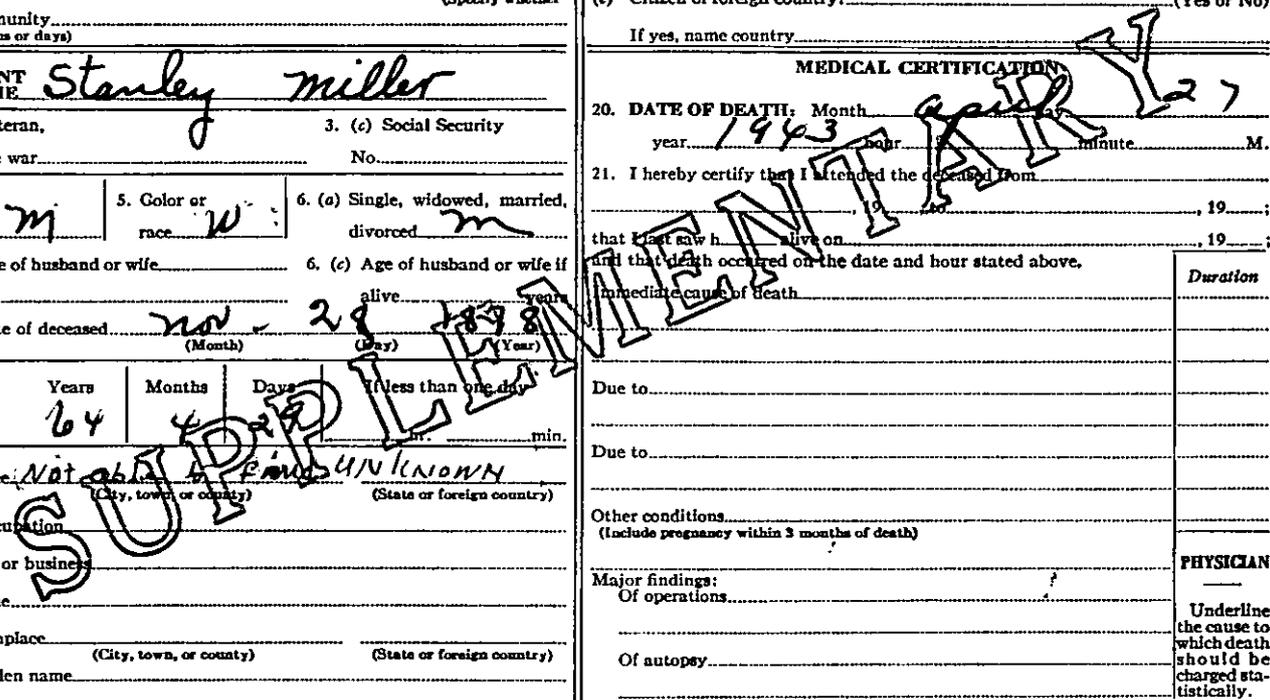
(b) Date of occurrence _____

(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) (e) Means of injury _____

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



PHYSICIAN _____

Underline the cause to which death should be charged statistically.

