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26390

JUN 10 1943

Registration District No. 349

Primary Registration District No. 6181

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Peru, Ind. Rural  
(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 Lifes years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County 105  
(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 5 day 20  
year 1943 hour 10:30 minute 17 M.  
21. I hereby certify that I attended the deceased from 4-22  
1943 to 5-20 1943  
that I last saw him alive on 5-19 1943  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Edsworth Andrew 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 Single  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: 10-20-1876  
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 0  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Araron Miller  
13. Birthplace Don't know Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Sprunger  
15. Birthplace Don't know Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant: Opul Santee  
(b) Address: Green Castle  
17. (a) Burial (b) Date thereof: 5-22-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sprunger Per

18. (a) Signature of funeral director: Edward E. Hunt, Sr.  
(b) Address: Green City Mo.  
19. (a) May 31-43 (b) Uinnie Davidson  
(Date received local registrar) (Registrar's signature)

Immediate cause of death: UREMIA  
Due to: Prostate  
Other conditions: \_\_\_\_\_  
(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: W. E. Schuchert (M.D. or other)  
Address: Green City Mo. Date signed: 5-24-43

RECEIVED

District Health Officer No. 10

District File Number 6-43-1000

Date Filed JUN 8 1943

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, Mo

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.

FILED BY COUNTY RE. 451103

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 349

Primary Registration District No. 6181

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Rural  
(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 Life \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Edwath A. 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 5

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

7. Birth date of deceased 10 20 1878  
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Allen E. Pent-son

(b) Address Green City MO

19. (a) 11/31-43 (Date received local registrar) (b) Uinice Davidson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Sullivan  
(c) City or town Green City Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 20 Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

S-19290