

Registration District No. **335** Primary Registration District No. **-6118 4492** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County **Scott**  
(b) City or town **Oran Missouri**  
(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

3. (a) PRINT FULL NAME **Walter Boggs. Miller.**  
3. (b) If veteran, name war **no** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife **Deceased** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Dec 21 1870**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>72</b>	<b>8</b>	<b>26</b>	_____ hr. _____ min.

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

10. Usual occupation **Farmer**

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

12. Name **Wilson S. Miller.**  
13. Birthplace **Ohio.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary Boggs.**  
15. Birthplace **Ohio.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Son, Wilson Miller.**  
(b) Address **St. Louis Missouri**

17. (a) **Removal.** (b) Date thereof **Sept 18th 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Elmore Ohio.**

18. (a) Signature of funeral director **Hessner Funeral Home**  
(b) Address **1074 Oran Missouri**

19. (a) **Sept 17 1943** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Scott**  
(c) City or town **Oran 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 **Sept** day **17** - 19**43**  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**Chronic Myocarditis**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

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 \_\_\_\_\_  
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 **[Signature]** (M.D. or other)  
Address **[Signature]** Date signed **9/17/43**

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

100  
8  
0

100

RECEIVED

District Health Office No. 2,

District File Number 1043-286

Date Filed 10-11-43

**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 Raymond D. Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.**