

No. 2
9-4-41
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39417**
Registrar's No. _____

FILED NOV 19 1943 374
Registration District No. _____

Primary Registration District No. **6272**

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

1. PLACE OF DEATH:

(a) County North

(b) City or town Rural - Allen Twp
(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 None (Specify whether _____)

In this community 25 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME IVA MAY 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, divorced Widowed

6. (b) Name of husband or wife Jack Miller

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

7. Birth date of deceased Sept 4 1884
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 0

If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm Henry McNeese

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

14. Maiden name Rachel Stone

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

16. (a) Informant Ray McLeod

(b) Address Danver, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Oct 6 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Praxis Chapel Cemetery

18. (a) Signature of funeral director Frank Quos

(b) Address Denver Mo

19. (a) Oct 10 - 1943 (Date received local registrar)

(b) Arlene Scadden (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County North **113**

(c) City or town 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 Oct day 4
year 1943 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from Jan - 2 1943 to Oct - 4 1943
that I last saw her alive on Oct - 3 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Uterus

Due to Widow

Due to _____

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

Major findings: Of operations _____

Of autopsy W

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 [Signature] (M.D. or other)

Address [Address] Date signed Oct 4 43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

110K

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..... *J P P*.....
Licensed Embalmer No..... *2947*.....
P. O. Address..... *Denver 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.