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FILED FEB 8 1944  
Registration District No. 3000

State File No. \_\_\_\_\_  
Registrar's No. 33

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

1. PLACE OF DEATH:

(a) County Adair Co.  
 (b) City or town Hicksville, Mo.  
(if outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Stechler Hospital  
(if not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
(Specify whether)  
 In this community Life  
years, months or days

3. (a) PRINT FULL NAME Lola Faye 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 M  
 6. (b) Name of husband or wife Wm. E. Miller 6. (c) Age of husband or wife if alive 35 years  
 7. Birth date of deceased 2 (Month) 29 (Day) 1916 (Year)

8. AGE: Years 27 Months 10 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name Jess Williams  
 13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Wardie Beck  
 15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Marie Miller  
 (b) Address Green castle, Mo.

17. (a) Green Burial (b) Date thereof 1-30-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Green Castle, Mo.

18. (a) Signature of funeral director Wm. E. Dent, Sr.  
 (b) Address Green City, Mo.

19. (a) 1/31/44 (b) Mrs. J. Warner  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. address - Green Castle  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27  
 year 1944 hour 5:00 minute \_\_\_\_\_ M. \_\_\_\_\_  
 21. I hereby certify that I attended the deceased from Jan 26 1944 to Jan 27 1944  
 that I last saw her alive on Jan 27 1944  
 and that death occurred on the (date and hour stated above).

Immediate cause of death Bacteriemia  
abscess appendix  
+ Bilateral Salpingitis  
 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) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
 23. Signature R. P. Stropler (M. D. or other) MD  
 Address Hicksville Mo Date signed 1-27-44

RECEIVED

District Health Officer No. 10

District File Number 2-44-286

Date Filed FEB 5 1944

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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, above space should be left blank.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB

Registration District No. 1Primary Registration District No. 3000Registrar's No. 33

## 1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirksville  
(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 NAMELola Faye Miller3. (b) If veteran,  
name war3. (c) Social Security  
No.4. Sex F 5. Color or race W 6. (a) Single, widowed, married,  
divorced m6. (b) Name of husband or wife 6. (c) Age of husband or wife if  
alive. years7. Birth date of deceased Feb. 29 1918  
(Month) (Day) (Year)8. AGE: Years 27 Months 10 Days 3 If less than one day  
min.9. Birthplace Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

15. Birthplace Mo.  
(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

(b) Address

19. (a) (Date received local registrar) (b) (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 day 27  
year 1945 hour 11 minute 37 M.21. I hereby certify that I attended the deceased from  
19 60 to 19 60that last saw him alive on 19 60  
and that death occurred on the date and hour stated above.  
Immediate cause of death

Duration

Due to Gonorrhea!

Due to

Other conditions  
(Include pregnancy within 3 months of death) 25!2Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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 Rostickler (M. D. or other) MD

Address Date signed

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

1887