

FILED FEB 1 1944

Registration District No. 59

Primary Registration District No. 5220

Registrar's No.

14

1. PLACE OF DEATH:

(a) County Cass
 (b) City or town Rural Collwater Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 34 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Henry 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 Married
 6. (b) Name of husband or wife Emma Miller 6. (c) Age of husband or wife if alive 56 years
 7. Birth date of deceased 2-15-1877
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 4 hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Fredrick Miller

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

14. Maiden name Anna Miller

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

16. (a) Informant Mrs. Emma Miller

(b) Address Bequel MO

17. (a) Burial (b) Date thereof 1-22-1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Freeman

18. (a) Signature of funeral director Altkman Bro.

(b) Address Archie MO

19. (a) Jan. 26, 1944 (b) Margaret Valler
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cass 19
 (c) City or town Rural Collwater Twp.
 (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 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19 1944
 year 1944 hour 11 minute 4 A. M.

21. I hereby certify that I attended the deceased from Jan. 19
1944 to Jan. 19, 1944

that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery lesion Duration _____

Due to arteriosclerosis probably

Due to _____

Other conditions (Include pregnancy within 3 months of death) 9 HA

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) (b) Means of injury _____

23. Signature E. E. Robinson (M. D. or other) _____

Address Adrian, Mo. Date signed 1-22-44

MOTHER FATHER

1047

(Licensed Embalmer's Statement on Reverse Side)

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 *personal*

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Hoyd Atkinson

Licensed Embalmer No. *3920*

P. O. Address

Harrisonville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.