

FILED MAR 11 1944

Registration District No. **184**

Primary Registration District No. **5359**

1. PLACE OF DEATH:
 (a) County **Daviess**
 (b) City or town **"Rural" Grand River Township**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home of Robert Miller
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 Day**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Daviess**
 (c) City or town **"Rural" Grand River Twp.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **8 Miles N. E. Gallatin, Mo.**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country **0**

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

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **February** day **20**
 year **1944** hour **10** minute **30** A. M.

4. Sex **Male** 5. Color or race **White**
 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 **April 13 1867**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb. 20 1944** to **Feb. 20 1944**
 that I last saw him alive on **Feb. 20 1944**
 and that death occurred on the date and hour stated above.

8. AGE: Years **76** Months **10** Days **7**
 If less than one day **---** hr. **---** min.

Immediate cause of death **Bronchial Pneumonia**
 Due to **---**
 Due to **---**
 Other conditions (Include pregnancy within 3 months of death) **---**
 Major findings: Of operations **---**
 Of autopsy **---**

9. Birthplace **Daviess County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Own Farm**

MOTHER { 12. Name **George W. Miller**
 13. Birthplace **Unknown Ohio**
(City, town, or county) (State or foreign country)
 14. Maiden name **Catherine D. Foster**
 15. Birthplace **Unknown Ohio**
(City, town, or county) (State or foreign country)

PHYSICIAN **---**
 Underline the cause to which death should be charged statistically.
107

16. (a) Informant **Robert Miller**
 (b) Address **Jameson, Missouri**

17. (a) **Burial** (b) Date thereof **2-22-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Grand River Cemetery**

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 **---**

18. (a) Signature of funeral director **Hone Funeral Home**
 (b) Address **Gallatin, Mo.**
 19. (a) **2-22-1944** (b) **L. P. Doolin**
(Date received local registrar) (Registrar's signature)

23. Signature **L. P. Doolin** (M. D. or other) **---**
 Address **Gallatin** Date signed **2-22-44**

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

JUL 30 1954

JUN 13 1957

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 L. O. Richerson
Licensed Embalmer No. 3302
P. O. Address Fallston, Md.

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.