

Registration District No. **77**

Primary Registration District No. **3016**

**1. PLACE OF DEATH:**

(a) County **Cole**  
(b) City or town **Jefferson City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **St. Mary's Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **10 days**  
In this community **31 yrs.**  
years, months or days (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Cole**  
(c) City or town **Jefferson City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **818-W-Main**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **Sophia Elizabeth Miller**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Fe** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Louis (Louis)** 6. (c) Age of husband or wife if alive **59** years  
7. Birth date of deceased **Dec. 26 1884**  
(Month) (Day) (Year)

8. AGE: Years **59** Months **1** Days **25** If less than one day hr. min.

9. Birthplace **Bumby Mo. 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business **at home**

12. Name **James Hickman**

13. Birthplace **Crest Orchard Ky. 1**  
(City, town, or county) (State or foreign country)

14. Maiden name **Rachel May**

15. Birthplace **Penn. 1**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Louis Miller**

(b) Address **818-W-Main**

17. (a) **Burial** (b) Date thereof **2-23-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Salt Cemetery (Bumby)**

18. (a) Signature of funeral director **James Service**

(b) Address **710 Jefferson**

19. (a) **2-23-44** (b) **Theresa Richter**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Feb.** day **21** year **1944** hour **3:30** minute **8** M.

21. I hereby certify that I attended the deceased from **2-11-44** to **2-21-44** that I last saw her alive on **2-21-44** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarct**  
**Coronary thrombosis**  
**Hypertension**  
Due to.....  
Due to.....  
Other conditions (Include pregnancy within 3 months of death) **30!**

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

Major findings: Of operations.....  
Of autopsy.....

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 **John W. McHenry** (M.D. or other)  
Address **Jefferson City Mo** Date signed **2/24/44**

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 3/3/44

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. H. Anderson  
Licensed Embalmer No. 3641

P. O. Address J. W. M.

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.