

S. No. 2
M-8-43
v. 5-17-39
I X37823

15790

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 14 1944
Registration District No. 337

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 108

Primary Registration District No. 4497

1. PLACE OF DEATH:
(a) County SHELBY
(b) City or town CLARENCE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none (Specify whether 1)
In this community LIFE TIME
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County SHELBY MO
(c) City or town CLARENCE
(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 _____

3. (a) PRINT FULL NAME MARGARET ANN MILLER
3. (b) If veteran, name war _____ No. _____
3. (c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day Wed 11th
year 1944 hour _____ minute _____ M.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife Francis Miller
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb (Month) 5th (Day) 1879 (Year)

21. I hereby certify that I attended the deceased from May 31 to Oct 11, 1944
that I last saw her alive on Oct 9, 1944
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>95</u>	<u>8</u>	<u>6</u>	hr. _____ min. _____

Immediate cause of death: Chronic myCarditis
Due to _____
Due to _____

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

Other conditions (Include pregnancy within 3 months of death):
Senile dementia
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation House Keeper

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

11. Industry or business _____

MOTHER FATHER
12. Name Not Known

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant LEONARD WALLACE

(b) Address CLARENCE MO

17. (a) BURIAL (b) Date thereof 10-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MAPLE WOOD

18. (a) Signature of funeral director Million + Baskew
(b) Address Clarence MO

19. (a) Nov. 1-44 (b) Mudge Good
(Date received local registrar) (Registrar's signature)

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 D. L. Hurlan (M. D. or other) _____
Address CLARENCE MO Date signed 10/10/44

1095 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 10
District File Number 17-44-1868
Date Filed NOV 10 1944

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

Henry G. Packard

Licensed Embalmer No.

3835

P. O. Address

Shelburne, 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.