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17-39
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Registration District No. **FILED NOV 20 1944**

Primary Registration District No. **5658**

Registrar's No. **116**

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **Mount Vernon**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **480 days**
In this community **480 days**
years, months or days

3. (a) PRINT FULL NAME **Henry John Miller**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **509-09-1371**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **None**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 23 1891**
(Month) (Day) (Year)

8. AGE: Years **53** Months **2** Days **20**
If less than one day hr. _____ min.

9. Birthplace **Kansas City** **Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Fred Miller**
13. Birthplace **Unknown** **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Angeline Hickey**
15. Birthplace **Texas County** **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. McMichael, Record Clerk**
(b) Address **Mo. State San. Mt. Vernon, Mo.**

17. (a) **Burial** (b) Date thereof **9/14/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Vernon City Cem**

18. (a) Signature of funeral director **Geo. B. Orsh**

(b) Address **Mt. Vernon Mo.**

19. (a) **Sept 14 44** (b) **X** **Andy Crawford**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**
(c) City or town **Joplin**
(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 **Sept.** day **12th**
year **1944** hour **4:20** minute **P** M.

21. I hereby certify that I attended the deceased from **May 21st**, 19**43** to **Sept. 12**, 19**44**;
that I last saw him alive on **Sept. 12**, 19**44**;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Pulmonary Tuberculosis About 6 yrs**
Advanced with great cavity on Rt.
Due to **death due to massive hemorrhage from Rt. lung cavity.**
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **13 h**
Of operations _____
Of autopsy _____

Duration _____
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?

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature **Andy Crawford** (M. D. or other) _____
Address **State Sanatorium** Date signed **9-12-44**
Geo. B. Orsh

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

RECEIVED

District Health Officer No. 8,

District File Number 1144-1152

Date Filed NOV 14 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.....

Was not Embalmed

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Geo B Orr

Licensed Embalmer No. *946*

P. O. Address.....

Mr Terson

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.