

S. No. 2
OM-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38993**

FILED DEC 13 1944

Registration District No. **341**

Primary Registration District No. **3075**

Registrar's No. **56**

1. PLACE OF DEATH:
 (a) County **Stoddard**
 (b) City or town **Dexter**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1**
(Specify whether
 In this community **1**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Stoddard 103**
 (c) City or town **Dexter 3**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **Gale Hines Miller**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **1**
 year **1944** hour **7** minute **25 p.m.**

4. Sex **Male 0** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Effie A. Miller** **6. (c) Age of husband or wife if alive** **65** years
7. Birth date of deceased **July 18, 1880**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10-23-1944** to **Nov 1-1944**
 that I last saw him **alive on Nov 1, 1944**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Arterial hypertension** **Duration 7 days**

8. AGE: Years **64** Months **3** Days **13** If less than one day
 hr. _____ min. _____

Due to **arterial sclerosis** **10 days**
 Due to _____

9. Birthplace **Millersville Mo. 0**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired**

Other conditions **ventr. bronchitis** **14 days**
(Include pregnancy within 3 months of death)

11. Industry or business
12. Name **George W. Miller**
13. Birthplace **Millersville Mo. 0**
(City, town, or county) (State or foreign country)
14. Maiden name **Emma Swan**
15. Birthplace **Oak Ridge Mo. 0**
(City, town, or county) (State or foreign country)

Major findings:
 Of operations **93d**
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Effie A. Miller**
(b) Address **Dexter, Mo.**
17. (a) Burial **Dexter, Mo. Cem.** **(b) Date thereof** **Nov. 3, '44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation

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 **0**

18. (a) Signature of informant **Blenkinship-Strickland**
(b) Address **Dexter, Mo.**
19. (a) 11-20-44 **(b) Nora Smith**
(Date received local registrar) (Registrar's signature)

23. Signature **Nora Smith** (M. D. or other) _____
Address **Dexter, Mo.** **Date signed** **11-15-44**

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

033

1134

RECEIVED

District Health Office No. 2,

District File Number 124-1563

Date Filed 12-7-44

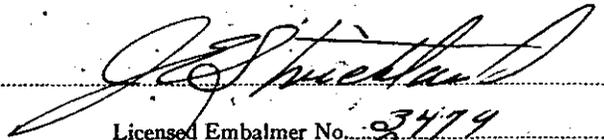
STATEMENT BY LICENSED EMBALMER

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


Licensed Embalmer No. 3479

P. O. Address: Dayton, OH

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.