

FILED JAN 5 2 1945

Registration District No. _____

Primary Registration District No. 4346

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Montgomery
 (b) City or town Montgomery City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
County Infirmary
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 yrs 5
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Frank Miller

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

4. Sex M 5. Color or race Col 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased un known
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
About 90				hr. _____ min.

9. Birthplace Middletown Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Un known

11. Industry or business no

MOTHER FATHER { 12. Name Un Known
 13. Birthplace no
(City, town, or county) (State or foreign country)
 14. Maiden name no
 15. Birthplace no
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Covington

(b) Address Montromery City Mo

17. (a) Burial (b) Date thereof 12-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Montgomery City Cem

18. (a) Signature of funeral director C. W. Hopkins

(b) Address Montgomery City Mo

19. (a) 12-28-44 (b) Mrs C. E. Vandover
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouriry (b) County Montgomery 70
 (c) City or town Montgomery
(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 12 day 23 rd
 year 1944 hour 2 Two minute 00 p.M.

21. I hereby certify that I attended the deceased from December 31, 1944, to December 23, 1944
 that I last saw him alive on Dec. 21, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Chronic Nephritis
 Due to Generalized Arteriosclerosis
 Due to Prostatism & Hemingy
retention & Anuria
 Other conditions severely
(Include pregnancy within 3 months of death)

Duration _____ years?
 _____ years?
 _____ days
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

Major findings:
 Of operations 12/21
 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?
(Specify type of place)
 While at work? _____ (e) Means of injury 0

23. Signature E. J. Anderson (M. D. or other) M.D.
 Address Montgomery City, Mo. Date signed 12/28/44

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-4-45

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.....

P. O. Address:.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 28

Registration District No. 231

Primary Registration District No. 4346

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Montgomery
(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 _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Frank Miller

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

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced unknown

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unknown

7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: Years 90 Months _____ Day _____ If less than one day _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOYER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 Jan year 194 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-41687 -1944