

FILED FEB 9 1945 82

Primary Registration District No. 4230

I. PLACE OF DEATH:

(a) County Howard
(b) City or town Armstrong
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
X
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X (Specify whether
In this community Entire life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard 45
(c) City or town Armstrong (If outside city or town limits, write "RURAL") 0
(d) Street No. X (If rural, give location)
(e) If foreign born, how long in U. S. A.? X 0 years.

3. (a) PRINT FULL NAME Addison Lewis Miller

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 2 yes

6. (b) Name of husband or wife Kate Belle Miller 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased: Dec. 3, 1862
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 26 If less than one day
hr. min.

9. Birthplace: Howard Co. U Missouri
(City, town or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

12. Name James Y. Miller

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

14. Maiden name Annaliza Miller

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

16. (a) Informant Isabelle Miller

(b) Address Fayette, Mo.

17. (a) Bureau (b) Date thereof Jan 31, 1945
(Burial, cremation, etc.) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Ridge

18. (a) Signature of funeral director Mary Oldaker

(b) Address Armstrong, Mo.

19. (a) 1/30/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29th
year 1945 hour 3 minute 10 A.M.

21. I hereby certify that I attended the deceased from Jan 29, 1945 to Jan 29, 1945
that I last saw him alive on Jan 29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial degeneration

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations [Signature]
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 0

23. Signature W. M. [Signature] (M. D. or other) MD
Address Armstrong, Mo. Date signed 1/30/45

Duration
PHYSICIAN
Underlines the cause to which death should be charged statistically.

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

300

7314

2-8-45

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 Mary Oldaker

Licensed Embalmer No. 3399

P. O. Address Armstrong, 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, above space should be left blank.