

FILED FEB 6 1945

Registration District No. **303**

Primary Registration District No. **6044**

1. PLACE OF DEATH:

(a) County **Rapley Co Mo**  
(b) City or town **Pine Bluff**  
(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 years, months or days)  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Ripley 91**  
(c) City or town **Pine Bluff**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **of U.S.A** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **William David Miller**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M. O** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **3** **3** divorced **3**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **April 29 1966**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **6** Days **15** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Retired Farmer**

11. Industry or business \_\_\_\_\_

12. Name **Joseph Miller**

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

14. Maiden name **Frances Haller**

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

16. (a) Informant **Mr. Miller**

(b) Address **Laurel, Ark**

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation **Pine Bluff**

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **1-27-1945** (Date received local registrar) **G. G. Sprague** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **16** - 1945  
year \_\_\_\_\_ hour **2:30** minute **15** M.

21. I hereby certify that I attended the deceased from **Jan 7** 1945 to **Jan 16** 1945  
that I last saw him alive on **Jan 15** and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **2 day**

Due to **Chronic heart for the past 10 years**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy **180**

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 **W. H. Hill** (M. D. or other)

Address **Alton Mo** Date signed **1/16/45**

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

MOTHER FATHER

D  
Health Officer No. 5,

File Number 24543

dated 2-5-45

**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.**

Registration District No. 303

Primary Registration District No. 6044

1. PLACE OF DEATH:

(a) County Pipley  
(b) City or town Princeton  
(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 Wm. D. Miller

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased April 29 (Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day) min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER 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) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director James H. Frank

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) W. H. Sprague (Registrar's signature) (Date received local registrar) \_\_\_\_\_

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 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the decedent from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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) \_\_\_\_\_

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(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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

3200