

FILED MAY 16 1945
 Registration District No. **286**

Primary Registration District No. **4178**

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

1. PLACE OF DEATH:
 (a) County **Dunklin**
 (b) City or town **Halscomb mo**
 (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 **8 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **Dunklin 34**
 (c) City or town **Halscomb mo** (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 - If yes, name country.

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **27** year **1945** hour **8** minute **5 A.M.**
21. I hereby certify that I attended the deceased from Feb 10, 1945
 _____, 19____, to **Apr 25**, 19**45**
 that I last saw her alive on **April 25**, 19**45**
 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Geo Miller** 6. (c) Age of husband or wife if alive **78** years
 7. Birth date of deceased **3 # - 9 27 1867**
 (Month) (Day) (Year)

Immediate cause of death **acute dilation of the heart with cardiac asthma**
 Due to **cholecystitis**
 Due to

8. AGE: Years **78** Months **1** Days **18** If less than one day hr. min.

Other conditions (Include pregnancy within 3 months of death) **no**
 Major findings: Of operations **no**
 Of autopsy

9. Birthplace **MO U** (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**
11. Industry or business
12. Name **Don't Know**
13. Birthplace **Don't Know** (City, town or county) (State or foreign country)
14. Maiden name **Don't Know**
15. Birthplace **Don't Know** (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Maxine Miller**
 (b) Address **2718 N. Wilton ave Chicago**
17. (a) Burial (b) Date thereof **4-29-45**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Post Oak**
18. (a) Signature of funeral director **W. H. Kirby**
 (b) Address **Rectory, Ash**
19. (a) 4/27/45 (b) **Mrs. Ernest Vanick, Jr.**
 (Date received local registrar) (Registrar's signature)

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 **D**
23. Signature **John T. Schuman** (M. D. or other) **MD**
 Address **Charleston mo** Date signed **4-27-45**

RECEIVED

District Health Office No.

District File Number 545-91

Date Filed 5-11-4

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 John R. Casner

Licensed Embalmer No. 2912

P. O. Address Rector, Ark

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.