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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED SEP 21 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3017

Registrar's No. 87

1. PLACE OF DEATH:

(a) County COOPER

(b) City or town BOONVILLE  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St Joseph Hospital - J  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 37 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MONITEAU

(c) City or town RURAL BINN  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINTED FULL NAME LEWIS F. MILLER

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

20. DATE OF DEATH: Month 8 day 14  
year 1945 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from 17 to 1945 on 8-14-45  
and that death occurred on the date and hour stated above.

4. Sex MALE (1) Color or race WHITE

5. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife SOPHIA MILLER

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased: 12 (Month) 4 (Day) 1879 (Year)

Immediate cause of death ACCIDENTAL  
Dislocation 3rd & Cervical Vertebra  
Impaction 3rd & 4th Cervical Vertebra  
Caused Paralysis

Duration 37 Days

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

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

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

8. AGE: Years 65 Months 8 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation FARMER

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

MOTHER FATHER

12. Name LEWIS MILLER

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

14. Maiden name ELIZABETH BURG

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

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

Of autopsy \_\_\_\_\_

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

16. (a) Informant SOPHIA MILLER

(b) Address GAMESTOWN

17. (a) BURIAL (b) Date thereof 8-16-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CONCORD CEM.

22. If death was due to external causes, fill in 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? \_\_\_\_\_

18. (a) Signature of funeral director C. ALBERT HORNBACH

(b) Address PRATIE HOME MO.

19. (a) 8-16-45 (b) Dr Chas. Swap  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature U L Meredith  
Address Pratie Home Mo Date signed 8-14

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

SEP 6 1945

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 C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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, fact should be so stated above.

Sept.

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Joseph Hosp  
(If not in hospital or institution, write street number or local no)

(d) Length of stay: In hospital or institution 37 da (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lewis F 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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Dec 4 - 1877  
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

MOTHER: { 12. Name \_\_\_\_\_

FATHER: { 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 Mo (b) County Moniteau

(c) City or town Linn  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 14 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ all day \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death accident

Due to Dislocation 3rd cervical vertebra

Due to Impaction 3rd dorsal vertebra

Other conditions caused paralysis  
(Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 1952 19

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 7-7-45

(c) Where did injury occur? Farm  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Farm

While at work? Yes (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W F Meredith (M. D. or other) W F Meredith

Address Boonville, Mo signed W F Meredith

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

SUPPLEMENTARY

S-27208