

No. 2  
4-13-40  
5-17-39  
I X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

27726

FILED AUG 18 1945 STANDARD CERTIFICATE OF DEATH

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

Registration District No. 169

Primary Registration District No. 5619

Registrar's No. 275

1. PLACE OF DEATH:

(a) County Knott  
(b) City or town Knott City, Leddots  
(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 65 yrs years, months or days)

3. (a) PRINT FULL NAME Alma Philomena Miller  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct 8 1863 (Month) (Day) (Year)

8. AGE: Years: 81 Months: 8 Days: 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Peter Bergman

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

14. Maiden name Mary Singer

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

16. (a) Informant Mrs Frank Hellingert  
(b) Address Knott City Mo

17. (a) Burial (b) Date thereof July 14 - 1945 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bee Ridge

18. (a) Signature of funeral director Walter  
(b) Address Knott City Mo

19. (a) 7-14-45 (b) Walter Northcutt (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

State MO (b) County Knott  
(c) City or town Rural Leddots (If outside city or town limits, write "RURAL")  
(d) Street No. 6 miles South Knott City (If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1945 hour 4 minute 30 P. M.  
21. I hereby certify that I attended the deceased from May 17 1945 to July 16 1945  
that I last saw her alive on July 18 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Poisoning Duration 2 weeks  
Due to Chronic Nephritis ?  
Due to \_\_\_\_\_

Other conditions Chronic Myocarditis  
(Include pregnancy within 3 months of death)  
& Senility  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy MIK

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 \_\_\_\_\_  
Signature Walter (M. D. or other) W.D.  
Address Knott City Mo Date signed 7/14/45

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

RECEIVED

District Head Officer No. 10

District File Number 8-45-1344

Date Filed AUG 15 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. 884

working under my personal supervision.

Signed

Fred Wolter

Licensed Embalmer No. 684

P. O. Address Moxley 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.

Registration District No. 169

Primary Registration District No. 5619

1. PLACE OF DEATH:

(a) County  Knox (Rural) Feddo )  
(b) City or town  (Rural) Feddo )  
(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  (Almira) )  
years, months or days

3. (a) PRINT FULL NAME  Almira P Miller

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

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

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

7. Birth date of deceased  Oct 8   
(Month) (Day) (Year)

8. AGE: Years  81  Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

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.  (Rural) Feddo )  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

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

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

SUPPLEMENTARY

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

S-27726