

FILED SEP 18 1945

Registration District No. 96 Primary Registration District No. 5-38-5 Registrar's No. 6-

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

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Charley Institution  
(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 63 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Dallas <sup>20</sup>

(c) City or town Charley <sup>0</sup>  
(If outside city or town limits, write "RURAL") <sup>0</sup>

(d) Street No. \_\_\_\_\_ (If rural, give location) <sup>0</sup>

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JACOB WILLIAM MILLER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2  
year 1945 hour 10 minute 15 p. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mela 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased May 28 1862  
(Month) (Day) (Year)

Immediate cause of death Arterial Sclerosis Duration \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>2</u>	<u>4</u>	hr. _____ min. _____

Due to Cerebral Hemorrhage

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

9. Birthplace Phelps Co. Mo (City, town or county) (State or foreign country)

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

10. Usual occupation farmer

Major findings: Of operations \_\_\_\_\_ Of autopsy S/S

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

12. Name Noah Miller

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

14. Maiden name Rozella (State or foreign country)

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Jesse Miller

(b) Address Marshfield Mo

17. (a) burial (b) Date thereof Aug 7 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshfield

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? \_\_\_\_\_

18. (a) Signature of funeral director J. B. Jones

(b) Address Phelps Co Mo

19. (a) 9-12-45 (b) James Peters  
(Date received local registrar) (Registrar's signature)

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

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

23. Signature J. B. Jones (M. D. or other) \_\_\_\_\_  
Address Phelps Mo Date signed Aug 2 1945

1470

**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..... *Maria B Jones*.....  
Licensed Embalmer No..... *4322*.....  
P. O. Address..... *Buffalo 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.**