

FILED OCT 15 1945

Registration District No. 20

Primary Registration District No. 5447

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Genery  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Howard Township  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Genery  
(c) City or town Howard Township Rural  
(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

Sarah Eliz. 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 married

6. (b) Name of husband or wife Cyrus Miller

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased July 17 1878  
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Howard Twp. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name James H. Forbie  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Jessie  
15. Birthplace Frankfort Ky  
(City, town, or county) (State or foreign country)

16. (a) Informant Cyrus Miller  
(b) Address Albany, Mo.

17. (a) Burial (b) Date thereof 8/21/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankfort

18. (a) Signature of funeral director Walter Broth  
(b) Address Albany, Mo.

19. Sept. 7-1945 (b) James H. Forbie  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month August day 19  
year 1945 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from June 1 1945 to 8-19-1945  
that I last saw her alive on 8-19-1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Mural Thrombosis sudden  
Due to Myocarditis 1 year  
Duration

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

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

Of autopsy 92%

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? \_\_\_\_\_

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

23. Signature Frank H. Rose (M. D. or other) M.D.  
Address Albany, Mo. Date signed 8-20-45

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

RECEIVED  
District Health Officer No. 11;  
District File Number  
Date Filed

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 JM

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Charles E. Brooks

Licensed Embalmer No. 3329

P. O. Address Albany, N.Y.

**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.**