

FILED OCT 29 1945

Registration District No. 19

Primary Registration District No. 4168

Registrar's No.

1. PLACE OF DEATH:

(a) County De Kalb

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

(c) Name of hospital or institution home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community: five years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County De Kalb ³²

(c) City or town Maysville ²
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) ⁰

(e) Citizen of foreign country? no (Yes or No) ⁰
If yes, name country _____

3. (a) PRINT FULL NAME ALBERT E MILLER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24
year 1945 hour 7 minute _____ A.M.

21. I hereby certify that I attended the deceased from Sept 22, 1945 to Sept 24, 1945.
I last saw him alive on Sept 22, 1945.
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 widow

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: June 19 1886
(Month) (Day) (Year)

Immediate cause of death Chronic Endocarditis

Duration ?

8. AGE: Years Months Days If less than one day

79 3 5 hr. _____ min.

Due to _____

Due to _____

9. Birthplace: Gentry co mo ¹¹
(City, town, or county) (State or foreign country)

Other conditions Epilepsy ^{5/21}
(Include pregnancy within 3 months of death)

10. Usual occupation farmer

11. Industry or business _____

Major findings:
Of operations _____

Of autopsy 92d

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

MOTHER FATHER

12. Name K. Z. Moore Miller

13. Birthplace Andrew County ¹⁷
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

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 _____

23. Signature W. H. ... M. D. or other MD
Address Maysville mo Date signed 9/29/45

16. (a) Informant Mrs Virgil Thornton

(b) Address Osborn mo

17. (a) Burial (b) Date thereof 9-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockester mo

18. (a) Signature of funeral director John Brown

(b) Address Maysville mo

19. (a) _____ (b) W. H. ...
(Date received local registrar) (Registrar's signature)

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

JUN 6 1945

W. J. ...

W. J. ...

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 G. Brown*
Licensed Embalmer No. *3933*
P. O. Address *Wayville 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.