

**FILED** NOV 14 1945  
Registration District No. **276**

Primary Registration District No. **5947**

Registrar's No. **6**

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Phelps Rural  
(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 years, months or days)

In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Phelps

(c) City or town 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 JENNIE MILLER

(b) If veteran name war ✓

(c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19  
year 1945 hour 7:42 minute 9 AM

21. I hereby certify that I attended the deceased from Sept 4 1944 to Oct 19 1945  
that I last saw her alive on Oct 15 1945  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife Frank Miller 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased: (Month) 6 (Day) 30 (Year) 1863

Immediate cause of death acute dilatation of heart Duration 4 days

Due to cardiac asthma 10 years

8. AGE: Years 82 Months 3 Days 19  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

9. Birthplace Collins (City, town, or county) (State or foreign country) 1

10. Usual occupation House wife

11. Industry or business no. Feeding

12. Name J. M. Feeding

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

14. Maiden name Don't know

15. Birthplace Don't know (City, town, or county) (State or foreign country)

16. (a) Informant Wm H. Bode

(b) Address \_\_\_\_\_

17. (a) Rural (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation Chaffee MO

18. (a) Signature of funeral director Wm H. Bode

(b) Address Phelps MO

19. (a) Oct 19 1945 (b) Chas E. Birmingham (Registrar's signature)

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

Of autopsy 9504

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 \_\_\_\_\_

23. Signature William H. Bode (M. D. or other) \_\_\_\_\_

Address St. James, Mo. Date signed \_\_\_\_\_

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

MOTHER FATHER

**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.....

*me*

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

working under my personal supervision.

Signed.....

*Paul E. Lickheller*

Licensed Embalmer No.....

*3546*

P. O. Address.....

*St. James m*

**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.**