

**FILED NOV 28 1945**

Registration District No. **11**

Primary Registration District No. **5040**

Registrar's No. **64**

1. PLACE OF DEATH:

(a) County **Barry**  
(b) City or town **Rural** *Exeter, Mo.*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **None** **Exeter, Mo. R#1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1** (Specify whether  
in this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**  
(c) City or town **Exeter, Mo. R#1**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Sarah Alice Miller**

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

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Albert Miller** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years **Dead**  
7. Birth date of deceased **March 19** **1888**  
(Month) (Day) (Year)

8. AGE: Years **57** Months **4** Days **22** If less than one day hr. \_\_\_\_\_ min \_\_\_\_\_

9. Birthplace **Missouri** (City, town, or country) (State or foreign country)

10. Usual occupation **Housewife**

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

MOTHER } 12. Name **John Miles**  
FATHER } 13. Birthplace **Missouri**  
14. Maiden name **Eunice Stallcup**  
15. Birthplace **Missouri**

16. (a) Informant **Velma Gill**  
(b) Address **Mandanola Colo.**

17. (a) **Burial** (b) Date thereof **Aug. 12 45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Rockiecomfort, Mo.**

18. (a) Signature of funeral director **Wm. M. ...**  
(b) Address **Wheaton, Mo.**

19. (a) **Oct. 29 - 1945** (b) **Grace Williams**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **10**  
year **1945** hour **5** minute **A. M.**

21. I hereby certify that I attended the deceased from **Aug 1**  
19 **1945** to **Aug 10 - 1945**  
that I last saw him alive on **Aug 9 - 1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart Disease 2 yrs**

Due to **Chronic Hypertension**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **1318**  
Of autopsy \_\_\_\_\_

Duration

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) \_\_\_\_\_ (Means of injury)  
23. Signature **John R. ...** (M. D. or other) **also**  
Address **Wheaton Mo** Date signed **Aug 16 1945**

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

500

1017

RECEIVED

District Health Officer No. 6;

District File Number 1145-1142

Date Filed NOV 17 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. \_\_\_\_\_, working under my personal supervision.

Signed

*Wm. Marvin Rognie*

Licensed Embalmer No.

*2442*

P. O. Address

*Wheaton, 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.