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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 11 1946

42325

Registration District No. 316

Primary Registration District No. 3059

State File No. 42325

Registrar's No. 250

1. PLACE OF DEATH:

(a) County ST Francois

(b) City or town BONNE TERRE, MO.
(If outside city or town limits, write "RURAL," and name of township)

(c) Name of hospital or institution:
Bonne Terre Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ST Francois

(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 SAMUEL M Miller

3. (b) If veteran, name war None

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 12
year 45 hour 6 minute 30 P.M.

4. Sex M 5. Color or race wh

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 24 1954
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-11 45 to 12-11 45
that I last saw him alive on 12-12 45
and that death occurred on the date and hour stated above.

8. AGE: Years 91 Months 5 Days 18
If less than one day _____ hr. _____ min.

Immediate cause of death Broncho-pneumonia Duration 1 d

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

Due to _____

Due to _____

10. Usual occupation Broom Maker

Other conditions As surgical neck L femur
(Include pregnancy within 3 months of death)
12-10-45

11. Industry or business _____

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Hope Ely

(b) Address Disc Run Mo

17. (a) Burial (b) Date thereof 12 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Williams Cemetery

18. (a) Signature of funeral director Miller Funeral Home

(b) Address Farmington Mo

19. (a) 12-13-45 (b) Either Rudloff
(Date received local registrar) (Registrar's signature)

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 N O Baehle (M. D. or other) _____
Address Desloge, Mo. Date signed 12-13-45

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

1367

(Licensed Embalmer's Statement on Reverse Side)

RECORDED

Health Officer No. 4

File Number 146-1522

Date Filed 1-9-46

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..... Paul H. Dugal

Licensed Embalmer No. 4120

P. O. Address Farmington 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 250

Registration District No. 316

Primary Registration District No. 3059

1. PLACE OF DEATH
(a) County St. Francois
(b) City or town Booneville
(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..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (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 Samuel M. Miller
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Aug 24, 1857
(Month) (Day) (Year)

8. AGE: Years 91 Months 7 Days 3 If less than one day
hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
year..... four..... minute..... M.
21. I hereby certify that I attended the deceased from..... to....., 19.....
that I last saw him..... alive on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
18 hours 10
18
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident by fall
(b) Date of occurrence day before death
(c) Where did injury occur Summit St. Francois MO
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
fall out of bed at family infirmary
Specify type of place) Means of injury
While at work.....
23. Signature W. C. Lee (M. D. or other) W. C. Lee
Date signed 6/14/46

SUPPLEMENTARY

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

42325