

FILED JAN 21 1946 STANDARD CERTIFICATE OF DEATH

Registration District No. 156

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Freeman Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 65 years. (Specify whether years, months or days)
In this community 65 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Cherokee
(c) City or town Lowell Kansas
(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 William L. Miller

3. (b) If veteran, name war
3. (c) Social Security No. 510-24-9145

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nora Miller
6. (c) Age of husband or wife if alive 1878 years
7. Birth date of deceased Sept 6 1878 (Month) (Day) (Year)

8. AGE: Years 67 Months Days If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Thor J. Miller
13. Birthplace Ind. (City, town, or county) (State or foreign country)
14. Maiden name Maryanna (City, town, or county) (State or foreign country)
15. Birthplace Ind. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nora Miller
(b) Address Lowell Kansas
17. (a) Removal (b) Date thereof 1-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Lowell Kansas

18. (a) Signature of funeral director J. Fancis Ware
(b) Address Baxter Springs
19. (a) 1-5-46 (b) C. D. James (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 30 year 1945 hour 7 minute 40 P. M.

21. I hereby certify that I attended the deceased from 1945 to 12-30-1945 (that I last saw him alive on 12-30-1945 and that death occurred on the date and hour stated above.)

Immediate cause of death: Carcinoma of Sigmoid Colon with intestinal obstruction
Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: 462
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) (e) Means of injury
23. Signature: H. L. Dogan M.D. (M. D. or other)
Address: Baxter Springs Date signed 1-2-46

100490
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Hoadins-Wene Funeral Home, Registered Apprentice No.....
working under my personal supervision.

Signed J. Lorie Wene
Licensed Embalmer No. 2880 mo.
P. O. Address Baxter Springs 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.