

No. 2-43
-17-39
X35697

FILED APR 5 1946
Registration District No. 233

Primary Registration District No. 5813

State File No. _____

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Montgomery (Rural)

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

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

(d) Length of stay: In hospital or institution _____
In this community 65 years (Specify whether years, month or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery

(c) City or town Wellsville Mo 2/
(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 Mollie Josephine 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, Widow

7. (b) Name of husband or wife W. H. Miller 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 22 - 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 3 day 9
year 1946 hour 4 minute 01 P.M.

21. I hereby certify that I attended the deceased from 8 am 15-46
to March 9 - 1946
that I last saw her alive on March 9, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 11 Days 15 If less than one day hr. 4 min. _____

9. Birthplace Ralls Co Mo. 1
(City, town or county) (State or foreign country)

10. Usual occupation at home

Immediate cause of death Coronary Artery Disease

Due to Sty per Tumor

Due to Diabetes mellitus

Other conditions! (Include pregnancy within 3 months of death) _____

MOTHER FATHER

11. Industry or business Same

12. Name Alpheus Payne

13. Birthplace Scott Co Virginia
(City, town or county) (State or foreign country)

14. Maiden name Virginia Payne

15. Birthplace Ralls Co Mo. 1
(City, town or county) (State or foreign country)

16. (a) Informant Clay P. Miller
(b) Address Wellsville Mo

17. (a) Barbar (b) Date thereof 3-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville Mo

18. (a) Signature of funeral director A. B. Wells
(b) Address Wellsville Mo

19. (a) 3-11-46 (b) Thos. Merritt
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy Chitwood

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature R. G. Starnford (M. D. or other) _____
Address Wellsville Mo Date signed 3-10-46

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 4-4-46

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 self

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed A. B. Miller

Licensed Embalmer No. 1588

P. O. Address Weller ville 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.

State File No. April
Registrar's No. 7

Registration District No. 233

Primary Registration District No. 5813

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town 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 _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Mellie J. Miller

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

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Mar 22 (Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____ (if less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 9
year 1956 hour _____ 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 _____

Duration

Due to Chronic hepatitis 5700

Due to _____

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

Major findings: Of operations _____

Of autopsy 3/2

ADDITIONAL
SUPPLEMENTARY
INFORMATION
SUGGESTED

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 _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

9105

SUPPLEMENTARY

10183