

No. 2
8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17532

State File No.

FILED JUN 13 1946
Registration District No. 257

Primary Registration District No. 3088

Registrar's No. 21

1. PLACE OF DEATH:
 (a) County NO DAWAY
 (b) City or town MAKVILLE
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Frances Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 20 1/2 days
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Andrew
 (c) City or town Rochester Township
(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 Jacob W. Miller
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 5 day 14
 year 1946 hour 5 minute 30 P.M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W 2
 6. (b) Name of husband or wife Maude Miller 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased unknown
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 17 May 1946 to 14 May 1946
 that I last saw him alive on 14 May 1946
 and that death occurred on the date and hour stated above.

8. AGE: 87 Years 3 Months 3 Days
If less than one day
 hr. _____ min. _____

Immediate cause of death Hypostatic Emphysema 3 da
 Due to Chronic myocarditis unknown

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

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

10. Usual occupation unknown

Major findings:
 Of operations _____
 Of autopsy 938
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business unknown

MOTHER FATHER
 12. Name unknown
 13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. Clara Karguth
 (b) Address Jamesport Mo

17. (a) _____ (b) Date thereof 5-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director E. G. Brett
 (b) Address Southern

While at work? _____
(Specify type of place)
 (c) Means of injury _____

19. (a) May 20-46 (b) Bess Holt
(Date received local registrar) (Registrar's signature)

23. Signature Jaramiah (M. D. or other) MD
 Address Jaramiah Date signed 16 May 46

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(Licensed Embalmer's Statement on Reverse Side)

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

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *E. C. Breit*

Licensed Embalmer No. *2630*

P. O. Address *Savannah 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.