No. 2
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 13 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17695

Registration District No. 280 Primary Registration District No. 6-966 Registrar's No. 21

1. PLACE OF DEATH:
(a) County: Platte
(b) City or town: Rural - Preston
(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 years, months or days)
In this community: 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Platte 83
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Charlie Anderson Miller
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: ✓
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: 10 (Month) 11 (Day) 66 (Year)
8. AGE: Years 79 Months 6 Days 18 If less than one day hr. min.
9. Birthplace: Platte Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: John L. Miller
13. Birthplace: Ky. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Annis Rice
15. Birthplace: Platte Co. Mo. (City, town, or county) (State or foreign country)
16. (a) Informant: Nobley Miller
(b) Address: Edgerton Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-1-46 (Month) (Day) (Yr.)
(c) Place: burial or cremation: Smith Cemetery
18. (a) Signature of funeral director: Rollins-Nash
(b) Address: Edgerton Mo.
19. (a) 6-3-46 (Date received local registrar) (b) Mrs. Ophia Rollins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 29 year 46 hour minute M.
21. I hereby certify that I attended the deceased from Feb 15 1946, to April 29 1946, that I last saw him alive on April 27 1946, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lung Abscess	
Due to: Pneumonia	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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? (e) Means of injury: 0
23. Signature: [illegible] (M. D. or other)
Address: Smithville Mo Date signed 5/3/46

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(Licensed Embalmer's Statement on Reverse Side)

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 Vivian R. Nash

Licensed Embalmer No. 3947

P. O. Address Edgerton 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.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 240 Primary Registration District No. 5965 Registrar's No. 22

1. PLACE OF DEATH:

(a) County Platte

(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)

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 Charlie A. 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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 11 (Day) 1866 (Year)

8. AGE: Years 79 Months 6 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 29
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lung Abscess	3 wks
Due to Pneumonia (lobar)	2 mo
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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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? (e) Means of injury

23. Signature [signature] (M. D. ~~or other~~)

Address Smithville Date signed 6-15-46

SUPPLEMENTARY

16475

17695