

Registration District No. 100

Primary Registration District No. 398

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

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Rural - Spring Creek Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(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 _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Near Salem
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Edward LeRoy 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 Married

6. (b) Name of husband or wife Lottie Miller

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased September 18 1886
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____
that I last saw not seen alive alive on _____
and that death occurred on the date and hour stated above.

8. AGE: Years 59 Months 9 Days 9
If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name William Miller

13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Miller

15. Birthplace No Record
(City, town, or county) (State or foreign country)

Immediate cause of death Acute cardiac failure?

Due to signed as coroner.

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

Major findings: Of operations g.O.O.

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant H. Salzwedel

(b) Address Salem, Missouri

17. (a) Removal (b) Date thereof 6/28/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Denver Colorado

18. (a) Signature of funeral director Earl K. Spencer

(b) Address Salem, Missouri

19. (a) 6-28-46 (b) M. M. Hart
(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 M. M. Hart, MD (M. D. or other) MD
Address Salem, Mo Date signed 6-28-46

RECEIVED

District Health Officer No. 5,

District File No. 746 398

Date Filed 7-9-46

ALL 8 877

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, ~~on~~.....

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

Signed Wm. W. McDonald

Licensed Embalmer No. Salem, Mo

P. O. Address 3806

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.