

No. 2  
1-5-43  
5-17-39  
I X36671

**FILED JUL 9 1946** STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 162

Primary Registration District No. 5595

Registrar's No. 25

**1. PLACE OF DEATH:**

(a) County JEFFERSON  
(b) City or town RURAL - ROCK TOWNSHIP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
NEAR MAXVILLE Mo. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community LIFE TIME  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County JEFFERSON  
(c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. NEAR MAXVILLE Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month JUNE day 10  
year 1946 hour 11 minute 30 A. M.  
21. I hereby certify that I attended the deceased from June 2  
1946 to June 10 1946  
that I last saw him alive on 6-10 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Thy. Myocarditis  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: Senility  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: abd.  
Of autopsy: \_\_\_\_\_  
**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 O. F. Reich (M. D. or other) \_\_\_\_\_  
Address Summawick, Mo. Date signed 6-12/46

**3. (a) PRINT FULL NAME**

LOUIS H. MILLER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. NONE

4. Sex MO

5. Color or race W.

6. (a) Single, widowed, married, divorced. MARRIED

6. (b) Name of husband or wife KATIE MILLER

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased JULY  
(Month)

8 1877  
(Day) (Year)

8. AGE: Years 68 Months 11 Days 2  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace ST. LOUIS Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER.

11. Industry or business GENERAL FARMING.

12. Name WILLIAM MILLER

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)

16. (a) Informant MRS KATIE MILLER  
(b) Address R. R. #1 SUMMSWICK Mo.

17. (a) BURIAL (b) Date thereof JUNE 13, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. JOHN'S CEM. BECK Mo.  
18. (a) Signature of funeral director HEILIGTAG FUNERAL HOME  
(b) Address Summawick Mo.  
19. (a) 6-13-46 (b) Phil J Kirk  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 7-8-46

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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 Arthur W. Heuligtay  
Licensed Embalmer No. 3872  
P. O. Address Kennswick Inc.

**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.**