

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2607 Penn Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 10 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2607 Penn Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Gottfred Miller

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

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

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

7. Birth date of deceased April 5 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>10</u>	<u>1</u>	hr. _____ min.

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

10. Usual occupation Retired Paper Mill worker

11. Industry or business Paper Mills.

MOTHER FATHER

12. Name Samuel Miller 5

13. Birthplace Unknown Switzerland
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Krebs

15. Birthplace Unknown Switzerland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marie Anna Feiger

(b) Address 2607 Penn St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof Febr. 8, 1947.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rosester Cemetery

18. (a) Signature of funeral director Halter Meierhoff

(b) Address 1946 Colhoun St. St. Joseph, Mo.

19. (a) 2-13-47 (b) G. B. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 6
year 1947 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from Feb 1, 1947, to Feb 6, 1947
that I last saw him alive on Feb 5, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 days

Due to Arteriosclerosis General.

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None 93A

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 0

23. Signature E. M. Jones (M. D. or other) M.D.
Address 312 Kirkpatrick Bldg. Date signed 2-2-47

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

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..... *Albert P. Harrington*

Licensed Embalmer No. 3258 Missouri

P. O. Address..... St. Joseph, 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.