

No. 2
2-43
5-17-39
X 25897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1947
137

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4641

State File No. _____

Registrar's No. 42

Registration District No. _____

Primary Registration District No. 4217

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Urish
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution at home in Urish, Mo.
(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

3. (a) PRINT FULL NAME Mauda Amanda Miller

3. (b) If veteran, name war 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband Rhoden Fleming Miller 6. (c) Age of husband 86 years

7. Birth date of deceased May 5 1865
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Frankfort, Herkimer Co., N.Y.
(City, town, or county) (State or foreign country)

10. Usual occupation House-wife

11. Industry or business House-keeper

12. Name Wm. Porter

13. Birthplace Edinburgh, Scotland
(City, town, or county) (State or foreign country)

14. Maiden name Susannah M. Bellinger

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Porter H. Miller
(b) Address Clinton, Mo.

17. (a) Burial (b) Date thereof Feb. 23, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Urish, Mo.

18. (a) Signature of funeral director W. J. Brown
(b) Address Urish Mo.

19. (a) 2-23-47 (b) P. P. Kenney
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Henry
(c) City or town Urish
(If outside city or town limits, write "RURAL")
(d) Street No. at home in Urish
(If rural, give location)
(e) Citizen of foreign country no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21
year 1947 hour 4:00 minute 5. A. M.

21. I hereby certify that I attended the deceased from Nov 1945 to February 20, 1947
that I last saw her alive on Feb. 20, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Dilatation Duration 3-4 mos?

Due to cardiac asthma 1-yr?

Due to _____

Other conditions Sanility 2 yrs
(include pregnancy within 3 months of death)

Major findings: Of operations 112
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 3
(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)
(c) Means of injury 0

23. Signature J. G. McDonald (M. D. or other) _____
Address Urish Mo Date signed 2/23/47

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

42
20

MOTHER FATHER

RECEIVED
District Health Officer No. 7,
Health Officer Number 2-47-182
3-3-47

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 R. R. Kenney.....

Licensed Embalmer No. 3099.....

P. O. Address Clinton 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.