

No. 2
12-45
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 2 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7726**
Registrar's No. **88**

Registration District No. **1** Primary Registration District No. **3000**

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

1. PLACE OF DEATH:
(a) County **Adair**
(b) City or town **Kirksville**
(c) Name of hospital or institution: **Laughlin Hosp 0**
(d) Length of stay: _____ (Specify whether _____)
In this community _____ (Specify whether _____)

3. (a) PRINT FULL NAME **Henry J. G. Miller**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** () race **White** 5. Color or race _____
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 26 - 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 5 29 hr. min.

9. Birthplace **Macon Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____
12. Name **Fredrick Miller** 4
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name **Carolina Gellin**
15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Hattie Miller**
(b) Address **Macon Mo**

17. (a) **Burial** (b) Date thereof **Mar 26 47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oakwood Cem**

18. (a) Signature of funeral director **Robert Skuman**
(b) Address **Macon Mo**

19. (a) **3-27-47** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Macon** 61
(c) City or town **Macon** (If outside city or town limits, write "RURAL") 2
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **23**
year **1947** hour **3:15** minute **7** M.
21. I hereby certify that I attended the deceased from **March 7**, 19**47**, to **March 23**, 19**47**.
that I last saw him alive on **March 23**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Uremia
Due to **Prostatic hypertrophy (probably benign)**
Due to _____
Other conditions **Suppurative Parotitis**
(Include pregnancy within 3 months of death)
Major findings: **Supra-pituitary bladder drainage**
Of operations _____
Of autopsy **137A**

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

22. If death was due to external cause, 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)
(c) Means of injury **2**
23. Signature **Carl Kuehling** (M.D. or other) **oo**
Address **Kirksville Mo** Date signed **3/26/47**

RECEIVED
District Health
District File Number
Date Filed APR 21 1947

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 Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon, Ga

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.