No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 25 1947

Registration District No. 76

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27202

Primary Registration District No. 5356

Registrar's No. 49

1. PLACE OF DEATH:

(a) County DALLAS

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

(c) Name of hospital or institution: /
(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 LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DALLAS

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

(d) Street No. WILSON TOWNSHIP
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME MARTHA CHRISTENE 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 WIDOWED

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

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

7. Birth date of deceased OCT 19 1865
(Month) (Day) (Year)

8. AGE: Years 81 | Months 9 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace DALLAS CO MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business .....

FATHER
12. Name POLK VEST
13. Birthplace DALLAS CO MO
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name BETSY FRANKLIN
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant JOHN FRANKLIN
(b) Address BUFFALO MO

17. (a) BURIAL (b) Date thereof 8-8-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CEDAR RIDGE

18. (a) Signature of funeral director L. B. JONES
(b) Address BUFFALO, MO

19. (a) 8-24-47 (b) Mrs J. B. Jones
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 7 year 1947 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from August 8 1947 to Aug 8 1947 that I last saw her alive on August 6 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Circulatory failure	1 wk
Due to: Mitral & aortic organic heart dis	years
Due to:	
Other conditions: None (Include pregnancy within 3 months of death)	

Major findings:
Of operations: None
Of autopsy: None

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? .....
(Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature G. Glummer (M. D. or other) MD

Address Buffalo MO Date signed 8-15-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 7.47-1022
Date Filed 8/29/47

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 .....

Licensed Embalmer No. 2008

P. O. Address .....

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.