

S. No. 2
M-8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31958

FILED OCT 13 '47
Registration District No. 257

Primary Registration District No. 3048

State File No. _____

Registrar's No. 222

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

1. PLACE OF DEATH:

(a) County Nodaway
 (b) City or town Maryville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth 113
 (c) City or town Sheridan 0
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Deacon E. Miller

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased April I 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>5</u>	<u>23</u>	hr. _____ min. _____

9. Birthplace Bedford - (rural) Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation shoe cobbler

11. Industry or business _____

MOTHER FATHER

12. Name John H. Miller

13. Birthplace Switzerland 5
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Cain

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

16. (a) Informant Porter Miller

(b) Address Conway, Iowa

17. (a) Burial (b) Date thereof Sept. 27, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Grove Cemetery

18. (a) Signature of funeral director Arch. C. Dangle

(b) Address Grant City, Mo

19. (a) 9-28-47 (b) Beas Holt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24 year 1947 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 22 Sept 1947 to 24 Sept 1947; that I last saw him alive on 24 Sept 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Asthma 10 yrs
Atherosclerotic Cardiovascular Disease 11

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 93D
 Of autopsy _____

Duration 10 yrs

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

22. If death was due to external causes, fill in the following:
 (c) 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 Frank B. Matterson (M. D. or other)
 Address Grant City, Mo Date signed 28 Sept 47

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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 Arch C. Dumble

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.