

No. 2
-1/47
5-17-39

National Office of Vital Statistics
FILED NOV 5 1947
Registration District No. **43**

Primary Registration District No. **5135**

Registrar's No. **379**

1. PLACE OF DEATH:

(a) County **Butler**

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

(c) Name of hospital or institution:
Name / Ash Hill Top
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **50 yo.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Butler** / 2

(c) City or town **Quilim** / 0
(If outside city or town limits, write "RURAL") / 0

(d) Street No. **R.R. # 1** / 0
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Jessie Watson Miles**

3. (b) If veteran, name war **none**

3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Anna Miles**

6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased **July 30 1881**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
66	2	19	_____ hr. _____ min.

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

10. Usual occupation **Farming**

11. Industry or business _____

MOTHER FATHER {

12. Name **William Miles**

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

14. Maiden name **Unknown**

15. Birthplace **Unknown** / 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Anna Miles**

(b) Address **Quilim, Mo. R. 1**

17. (a) **Burial** (b) Date thereof **10-20-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Stanfield**

18. (a) Signature of funeral director **Gandess Funeral Home**
(b) Address **Campbell**

19. (a) **10-28-47** (b) **R. M. Nuttall**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **19th**
year **1947** hour _____ minute **5:40 A.M.**

21. I hereby certify that I attended the deceased from **Oct 17 1947** to **Oct 19 1947**
that I last saw him alive on **Oct 19 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Hypertension**

Due to _____

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

Major findings:
Of operations _____

Of autopsy **§ 3 A**

PHYSICIAN _____
Underline the cause of 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 _____

Signature **H. J. Campbell** (M. D. or other) **MD**

Date signed **10/24/47**

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

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RECEIVED

District Health Office No. 2,

District File Number 142-1420

Date Filed 11-3-47

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

Christina M. Landers

Licensed Embalmer No. 4227

P. O. Address Campbell, 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.