

FILED NOV 15 1947

Registration District No. **3373**

Primary Registration District No. **6196**

Registrar's No. **18**

1. PLACE OF DEATH:

(a) County **Texas**
(b) City or town **Rural Sherrill**
(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 **26 yrs** (Specify whether years, months or days)
In this community **26 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Texas '07**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **4 1/2 W. S. of Ricking**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **James H. Miller**

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

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Florence Miller** 6. (c) Age of husband or wife if alive **47** years
7. Birth date of deceased **April 18, 1874** (Month) (Day) (Year)

8. AGE: Years **73** Months **5** Days **27** If less than one day hr. min.

9. Birthplace **Marysville Kans** (City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business

12. Name **John S. Miller**

13. Birthplace **Not known** (City, town, or county) (State or foreign country)

14. Maiden name **Not known**
15. Birthplace **Not known** (City, town, or county) (State or foreign country)

16. (a) Informant **Lawrence S. Miller**

(b) Address **Ricking MO**

17. (a) **Burial** (b) Date of death **10-17-47**
(Burial, cremation, or recovery) (Month) (Day) (Year)

(c) Place: burial or cremation **Booneville Tenn**

18. (a) Signature of funeral director **Smith & Johnson**

(b) Address **Ricking MO**

19. (a) **Oct. 28, 1947** (b) **Eloora Hesse**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **15**
year **1947** hour **7** minute **15 A.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis**
rec. insularly

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **Q/A**
Of autopsy

Duration

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **L. Richard** (M. D. or other) **MA**

Address **Ricking MO** Date signed **10/16/47**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,
District No. 147.653
Date Filed 11-13-47

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 Hubert E. Ferguson
Licensed Embalmer No. 3945
P. O. Address Licking MS

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.