

No. 2
12-45
17-39
X47070

FILED JUN 18 1948

Registration District No. 157

Primary Registration District No. 5575

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Hickman Mills
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Banister Road & Blue Ridge
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 4 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Hickman Mills
(If outside city or town limits, write "RURAL")
(d) Street No. Banister Road & Blue Ridge
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1948 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from Crownier, 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 sclerosis
Due to arterio sclerosis

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

Major findings:
Of operations 07
Of autopsy no
History of 29 injection

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 James H. Hodges (M. D. or other)
Address 1424 1/2 N. 11th Date signed 6-4-48

3. (a) PRINT FULL NAME RACHEL MILLER

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Jessie Miller 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased September 4 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 8 28 hr. _____ min.

9. Birthplace Cooper County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business X

12. Name Francis Bridewater

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Essie May Sims

(b) Address R. R. #1 Washington, Mo

17. (a) Burial (b) Date thereof June 5, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Missouri

18. (a) Signature of funeral director Sweeney Funeral Home
(b) Address Marshall, Missouri

19. (a) June 4 1948 (b) Deluxie H. Hodges
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

48
000

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

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 *Chas E. Wilks*

Licensed Embalmer No. *2644*

P. O. Address *H. C. 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 16

Registration District No. 154 Primary Registration District No. 5575

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Hickman Mills
(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 _____)
In this community _____ years, months or days (Specify whether _____)

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 4 (Month) (Day) (Year)

8. AGE: Years 87 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 4 - 48 (b) Dr. Dennis S. Hedge
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____

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

Major findings:
Of operations _____
Of autopsy _____

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 _____
Signature _____ (M. D. or other)
Date signed _____

SUPPLEMENTARY

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

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

S-19793