

FILED SEP 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25463

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 231

1. PLACE OF DEATH:

(a) County Lewis Boone Columbia
 (b) City or town Wyaconda, Missouri (Rural)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 22 days
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Medley Miller3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex Male 5. Color or
race White6. (b) Name of husband or wife
June Edna Miller7. Birth date of deceased May 11 95
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
53 3 22 hr. min.9. Birthplace Carthage, Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Farmer11. Industry or business Farmer12. Name Thomas Miller 913. Birthplace Unknown
(City, town, or county) (State or foreign country)14. Maiden name Loretta Humston15. Birthplace Missouri
(City, town, or county) (State or foreign country)16. (a) Informant Hospital Records(b) Address Columbia Mo17. (a) Burial & Removal (b) Date thereof Sept - 6 - 1948
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Midway Cem La Belle Mo18. (a) Signature of funeral director Parson Funeral Service(b) Address Columbia, Mo19. (a) 9-4-48 (b) Mrs. R.E. Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis 56
 (c) City or town Wyaconda, Missouri (Rural) 6
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location) 1
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9
year 1948 hour 8 minute 20 P.M.21. I hereby certify that I attended the deceased from
7-12 1948, to Sept 3 1948that I last saw him alive on Sept 3 1948
and that death occurred on the date and hour stated above.Immediate cause of death Bronchopneumonia
Locheux Acumia 7 mos.Due to Enterococcal pneumonia of
subeal mucosa of oral cavity

Due to _____

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

Major findings:

Of operations _____

Of autopsy 45E

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 J. Damers (M. D. or other)
State Cancer Hospital, Columbia Mo Date signed Sept 4, 1948

RECEIVED
District Health Officer No. 9,
District File Number
SEP 6 - 1948
Date Filed

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 Tom M. Harg
Licensed Embalmer No. 4869
P. O. Address Columbia

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.

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(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ellis Fuchel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo 22 da
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME medley miller

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased may 11
(Month) (Day) (Year)

8. AGE: Years 53 Months _____ Day _____ If less than one day _____ hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. P. E. Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lewis
(c) City or town Wyaconda
(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 _____ 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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-25463

1948