

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 120

Primary Registration District No. 4197

1. PLACE OF DEATH:

(a) County Gentry
(b) City or town Stanberry
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rest Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Albert Oren 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 August 27 1871
(Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Gentry Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Allen C. Miller
13. Birthplace Gentry Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Robertson
15. Birthplace Gentry Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Miller
(b) Address Darlington, Mo. R.F.D.
17. (a) Burial (b) Date thereof 12-8-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion
18. (a) Signature of funeral director [Signature]
(b) Address Albany, Missouri

19. (a) Dec. 8 - 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6
year 1948 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from Nov 23rd 1948 to Dec 6th 1948
that I last saw him alive on Nov 23rd 1948
and that death occurred on the date and hour stated above.

Immediate cause of death acute (uraemia) Poisoning Duration Unknown

Due to acute Cerebral Hemorrhage 3 Weeks P. M.

Due to _____

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

Major findings: Of operations _____

Of autopsy 930

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 [Signature] (M. D. or other) Phys.
Address Albany Mo Date signed 8-15

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

MOTHER, FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed *Charles Edward Bush*

Licensed Embalmer No. 3329

P. O. Address Albany, 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.