

FILED JAN 7 1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42217**
Registrar's No. **65**

Registration District No. **377**

Primary Registration District No. **4507**

1. PLACE OF DEATH

(a) County **Stam**
(b) City or town **Crane**
(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

3. (a) PRINT FULL NAME

Dacie Miller

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

4. Sex **Female** 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 **Nov 17 1919**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 11 14 hr. _____ min.

9. Birthplace **no** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Joe Miller**

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

14. Maiden name **Lamar Swann**

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

16. (a) Informant **Clara Miller**

(b) Address **Crane mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-1-48** (Month) (Day) (Year)

(c) Place: burial or cremation **Crane mo**

18. (a) Signature of funeral director **Lucy H. Manore**

(b) Address **Crane mo**

19. (a) **Dec. 23-48** (Date received local registrar) (b) **Lena Murray Dep** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Stam 117**
(c) City or town **Crane** (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 **Oct** day **31**
year **1948** hour **2** minute **30 A. M.**

21. I hereby certify that I attended the deceased from **July** 1948, to **Oct 18** 1948, that I last saw her alive on **Oct 18** 1948, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of rectum**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **16 D**

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? _____

23. Signature **Dr. W. W. Worman** (M. D. or other) **M.D.**

Address **Crane mo** Date signed **11-1-48**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 149-10

Date Filed 1-5-49

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

George H. Membre

Licensed Embalmer No. 3821

P. O. Address

Clear mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 347

Primary Registration District No. 4507

Registrar's No. 659

1. PLACE OF DEATH:
 (a) County Stone
 (b) City or town Crane
(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 years, months or days)

3. (a) PRINT FULL NAME Bellie 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 S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
 7. Birth date of deceased Nov-17
(Month) (Day) (Year)

8. AGE: Years 68 Months _____ Day _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife
 11. Industry or business House wife

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) _____
(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 _____ Year 1948 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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

Major findings:
 Of operations _____
 Of autopsy _____

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

SUPPLEMENTARY

