

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39970

State File No. ....

FILED DEC 27 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 46 PRIMARY REG. DIST. NO. 4065 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>Caldwell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Caldwell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Polo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Polo Mo 0130</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>U</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED. (Type or Print) a. (First) <u>Truman J.</u> b. (Middle) <u>Miller</u> c. (Last) <u>Miller</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 16 1950</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 21-1892</u>	9. AGE (In years last birthday) <u>58</u>	10. MONTHS <u>2</u> 11. DAYS <u>25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Ray Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U</u>
13a. FATHER'S NAME <u>John Miller</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Pryor</u>		14. NAME OF HUSBAND OR WIFE <u>Jo W. Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>U</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Joan Miller</u> ADDRESS <u>Polo Mo</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>many years</u> <u>many years</u> <u>many years ago</u> <u>42 22</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1848, to Dec 16, 1950, that I last saw the deceased alive on Dec 16, 1950, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. E. Goldberger</u> (Degree or title)	23b. ADDRESS <u>Braymer Mo.</u>	23c. DATE SIGNED <u>12/17/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-18-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson</u>
24d. LOCATION (City, town, or county) (State) <u>Lawson Mo.</u>		

DATE REC'D BY LOCAL REG. <u>Dec 18/50</u>	REGISTRAR'S SIGNATURE <u>Gladys Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alspaugh &amp; Cowley</u> ADDRESS <u>Polo Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Wayne H. Hallman

Licensed Embalmer No. 4627

P. O. Address Polo 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.