

FILED AUG 11 1951

STANDARD CERTIFICATE OF DEATH

State File No. **22361**
 Registrar's No. **67**

BIRTH NO. _____ REG. DIST. NO. **55** PRIMARY REG. DIST. NO. **3011**

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Carroll	
b. CITY (If outside corporate limits, write RURAL and give township) Carrollton Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Carrollton Missouri, R.R. 1.	
c. LENGTH OF STAY (in this place) 3 Month		d. STREET ADDRESS (If rural, give location) 8 Miles Nort West Carrollton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Staton Hospital.			

3. NAME OF DECEASED a. (First) William b. (Middle) Miller c. (Last) Miller			4. DATE OF DEATH (Month) (Day) (Year) July 21 1951		
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5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Nov 11 1867.		9. AGE (In years last birthday) 83.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY FARM			11. BIRTHPLACE (State or foreign country) Carroll County Missouri.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
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13a. FATHER'S NAME Daniel Miller			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE None		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Herman W. Miller		ADDRESS Carrollton Mo	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Unknown DUE TO (c)					
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		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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	
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22. I hereby certify that I attended the deceased from **April 17 1951** to **July 21 1951**, that I last saw the deceased alive on **July 21 1951**, and that death occurred at **1:35 p.m.** from the causes and on the date stated above.

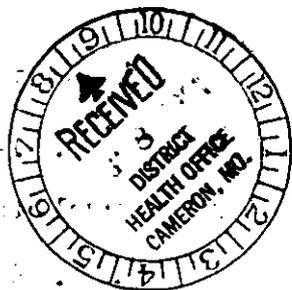
23a. SIGNATURE (Degree or title) H. Hamilton Stearns, M.D.			23b. ADDRESS Carrollton Mo			23c. DATE SIGNED July 23 1951		
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 24 1951		24c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery.		24d. LOCATION (City, town, or county) (State) 1 Mile North Norborne.	
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DATE REC'D BY LOCAL REG. 7/26/51		REGISTRAR'S SIGNATURE Mr. Herbert Calvert		25. FUNERAL DIRECTOR'S SIGNATURE John G. Dutch Jr		ADDRESS Norborne	
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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 me

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed John H Deitch Jr

Licensed Embalmer No. 4797

P. O. Address Harborne

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.