

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

26163  
Do not use this space.

DEAD AUG 16 1939

**1. PLACE OF DEATH**

(a) County Lemmon Registration District No. 508  
 (b) Township Creek Ridge Primary Registration District No. 5077  
 (c) City Chula or (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

KATHRYN JOAN MILLER  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13 1938  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Daytonport I  
Iowa

FATHER 13. NAME Edward H Miller 5

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Milan Mo

MOTHER 15. MAIDEN NAME Doris L Miller

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Euersonville Mo

17. INFORMANT (ADDRESS) Edward W Miller  
Blue Grass Towa

18. BURIAL, CREMATION, OR REMOVAL PLACE Plainview DATE Aug 2 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. J Robertson  
Laredo Mo

20. FILED 8-2 1939 H. M. Croase, M.D.  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/1 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 7/31 1939 to 8/1 1939  
 I last saw her alive on 7/31 1939 Death is said to have occurred on the date stated above, at 12:10Am.  
 The principal cause of death and related causes of importance were as follows:

BRONCHIAL-PNEUMONIA Date of onset 7/26  
INFLUENZA 7/23  
DYSENTERY  
 12 C  
 Other contributory causes of importance:  
Malnutrition  
DIARRHEA  
Dehydration

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) A. M. Croase SO.  
Chula, Mo. (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED  
FIRM... Office No. 111  
839-992  
AUG 9 1939

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 E. J. Robertson  
Licensed Embalmer No. 2465  
P. O. Address Farede, 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, above space should be left blank.