

Registration District No.

806

Primary Registration District No.

4485

Registrar's No.

1. PLACE OF DEATH:

(a) County Schuyler 2
(b) City or town Queen City, Mo.
(c) Name of hospital or institution: None
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Schuyler
(c) City or town Queen City
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Sarah Jane Miller 460

3. (b) If veteran, name war _____ 8. (c) Social Security No. No

4. Sex Female 5. Color or White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband Jacob Miller (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased 8 6 1852
(Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 18
If less than one day _____ hr. _____ min.

9. Birthplace Williams Town Lewis Co, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation General House Work

11. Industry or business _____

12. Name Levy Bowen

13. Birthplace New Jersey
(City, town, or county) (State or foreign country)

14. Maiden name Meriah Zuck

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

16. (a) Informant Chloa M. Bowen

(b) Address Queen City MO

17. (a) Burial Myers Cem Date thereof 12/27-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myers Cemetary

18. (a) Signature of funeral director Wm A West

(b) Address Queen City MO 718

19. (a) 12/26-1939 (b) J. Jones (c) J. Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 25
year 1939 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec 23, 1939, to Dec 25, 1939,
that I last saw her alive on Dec 25, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis

Due to Arteriosclerosis Rheumatism Months
Arteriosclerosis Rheumatism

Due to _____

Other conditions 93A
(Include pregnancy within 3 months of death)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 3

23. Signature O. P. Lyon (M. D. or other) DO
Address Queen City Date signed Dec 26

Duration 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

98
5
0

RECEIVED

District Health Officer No: 10

District File Number 1-40-138

Date Filed JAN 10 1940

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 Myself

Registered Apprentice No. 2882

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P.O. Address _____

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.