

17770

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUN 30 1940

Registration District No. _____

Primary Registration District No. 5011

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Rural Lincoln Township
(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 9
In this community 70 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Benjimen Ruben Miller
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Nannie Miller 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased 7 3 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 10 9 hr. min.

9. Birthplace Andrew County Mo.
(City, town, or county) (State or foreign county)

10. Usual occupation Farmer @ Presiding Judge
11. Industry or business of Andrew County Court

MOTHER FATHER
12. Name William Miller
13. Birthplace Lafalet County Ind.
(City, town, or county) (State or foreign county)
14. Maiden name Charady Burns
15. Birthplace Lafalet County Ind.
(City, town, or county) (State or foreign county)

16. (a) Informant's own signature _____
(b) Address Savannah Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5 14 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Savannah

18. (a) Signature of funeral director E. C. Breit
(b) Address Savannah Mo.

19. (a) May 14 - 40 (Date received local registrar) (b) J. W. Holcomb (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
(c) City or town Rural Lincoln Township
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 12
year 1940 hour 12 minute 25 p. M.

21. I hereby certify that I attended the deceased from April 27th, 1940, to May 12th, 1940
that I last saw him alive on May 12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion Duration 4 days
Due to Myocarditis Badly 15 days
Due to Pulmonary pneumonia 15 days

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

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
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) Means of injury _____
23. Signature J. W. Holcomb M.D. (M. D. or other) _____
Address Savannah Mo. Date signed 5-13-40

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

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.

Rev. 5-17-39
1 x 11

94A

RECEIVED
District Health Officer No. 11,
District File Number 640-939.
Date Filed JUN 1 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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed E. C. Breit
Licensed Embalmer No. 2650
P. O. Address Savannah 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17770

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 8

Primary Registration District No. 2011

Registrar's No. _____

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

ROWARD
MAGDORE

1. CAUSE OF DEATH:
 (a) County Andrew
 (b) City or town Lincoln T. 19
 (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 Benjamin Ruben Miller
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 10 9 hr. min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (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) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH Month 5 day 12 year 1970 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis

Due to myocarditis

Due to bad teeth
Pneumonia
(Bronchial)

Other conditions (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) (c) Means of injury _____

23. Signature B. R. Kelley (M. D. or other) _____

Address Savannah Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

ms

S-17770