

FILED JAN 9 1943

Registration District No. 1 32

Primary Registration District No. 3021

Registrar's No. ....

1. PLACE OF DEATH:

(a) County BRUNDY  
(b) City or town TRENTON  
(If outside city or town limits, write "RURAL", and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. .... (Specify whether  
In this community LIFE  
years, months or days)

3. (a) PRINT FULL NAME FRANK 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 SINGLE

6. (b) Name of husband or wife. .... 6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased OCT 3 1876  
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 7 If less than one day hr. min.

9. Birthplace MISSOURI (City, town, or county) (State or foreign country) 0

10. Usual occupation FARM HAND

11. Industry or business

MOTHER FATHER { 12. Name DEWITT MILLER  
13. Birthplace OHIO (City, town, or county) (State or foreign country)  
14. Maiden name FUNICE K. GARDNER  
15. Birthplace MISSOURI (City, town, or county) (State or foreign country)

16. (a) Informant BURNIT SHEPPARD

(b) Address TRENTON MO.

17. (a) BURIAL (b) Date thereof 12/12/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MELBOURNE MO

18. (a) Signature of funeral director GIBSON FUN. HOME

(b) Address TRENTON MO.

19. (a) 12-10-42 (b) Jada Hoffman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BRUNDY  
(c) City or town TRENTON  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? .... (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10  
year 1942 hour 9 minute 00 M.

21. I hereby certify that I attended the deceased from As Coroner 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 Natural Death  Duration  
Due To Unknown Causes

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ..... Of autopsy ..... **PHYSICIAN**

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 0

23. Signature Mona Zusan (M. D. or other) MD

Address Trenton MO Date signed 12-10-42

1202

JAN 1 1943

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. M. Jones*

Licensed Embalmer No. *3453*

P. O. Address *Trouton, W.*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 40844

Registration District No. 732

Primary Registration District No. 3021

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Grundy

(b) City or town Trenton  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Grundy

(c) City or town Trenton  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Miller

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race wh 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 3 - 1876  
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days \_\_\_\_\_ (If less than one day) min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Delmit Miller

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

14. Maiden name Emilee Gardner

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Natural death - due to unknown causes  
Arteriosclerosis and Chronic myocarditis  
Due to Arteriosclerosis and Chronic myocarditis  
Due to Arteriosclerosis and Chronic myocarditis

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
\_\_\_\_\_  
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)

(b) 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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

