

LED SEP 4 1943
Registration District No. 304

Primary Registration District No. 6237

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Rural Hickory Grove
(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 _____
years, months or days

8. (a) PRINT FULL NAME Nellie J Miller
8. (b) If veteran, name war _____
8. (c) Social Security No. _____

4. Sex F 5. Color or race W.
6. (a) Single, widowed, married, 2 divorced Widowed
6. (b) Name of husband or wife Frank B. Miller
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 4 1870
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Keeping

11. Industry or business _____

12. Name Lewis Hatt

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's own signature Mrs Fred Faye

(b) Address St Louis Mo

17. (a) Burial (b) Date thereof Aug 11 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wright City Cem

18. (a) Signature of funeral director J. H. Burg F&WCO

(b) Address Wright City Mo

19. (a) Aug 11 43 (b) Julius Reburg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Warren
(c) City or town Rural Hickory Grove
(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 August day 9
year 1943 hour 10:00 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from August 15, 1943 to August 9, 1943;
that I last saw her alive on August 7, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral lesion of the heart accompanied by enlargement of some

Due to Immediate cause of death - Uraemia

Due to _____

Other conditions Seriousness and high blood pressure
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration Several Years

6 days

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)

(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 _____

23. Signature John H. Dyer (M. D. or other) _____
Address Warrens Mo Date signed 8/9/43

MOTHER FATHER

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..... *Julius J. Niebur*.....

Licensed Embalmer No..... *3366*.....

P. O. Address..... *Wright Ct*.....

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.

Registration District No. 364

Primary Registration District No. 6237

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Warren
(b) City or town Rural Hickory Grove Twp
(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 _____ (Specify whether _____)
years, months or days)
3. (a) PRINT FULL NAME Nellie J. Miller
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased See 4 1870
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days _____ If less than one day, _____ min.
9. Birthplace _____ (City, town, or county) (State or foreign country) Ohio

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month aug year 1943 day _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 myocardial lesion of infarction enlarged of some
Due to Immediate cause of death uremia of 6 days
Due to following chronic nephritis
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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

10 SET

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