o. 2
-42
7-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31123

FILED OCT 7 1943
Registration District No. 1943

Primary Registration District No. 2005

Registrar's No. 56

1. PLACE OF DEATH:
(a) County Bates
(b) City or town Butler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 104 N. Broadway
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DEACESED:
(a) State Mo. (b) County Bates
(c) City or town Butler
(If outside city or town limits, write "RURAL")
(d) Street No. 104 N Broadway
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ida Jane Miller
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife John D Miller
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Nov. (Month) 15 (Day) 1873 (Year)

8. AGE: Years 70 Months 10 Days 2 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Huston Mallett
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sandeback
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant John D Miller
(b) Address Butler Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill
18. (a) Signature of funeral director Culvers
(b) Address Butler Mo
19. (a) Sept 20, 1943 (Date received local registrar) (b) Pauline Crumpton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from Sept. 10th 43 to Sept. 17 1943 that I last saw her alive on Sept. 17 1943 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Carcinomas Colon
Due to
Due to Carcinoma Colon
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Carter W. Lute (M. D. or other) M.D.
Address Butler Mo Date signed 9/18/43

1366 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 9-43-981
Date Filed 10-5-43

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 C. E. Culver

Licensed Embalmer No. 2576

P. O. Address Butler 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, fact should be so stated above.

No. 2B
I—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

0 OCT -

State File No.

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 56

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Butler
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Ida Jane 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. 15 (Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country) (not known)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17 year 1943 hour minute M.

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

Immediate cause of death — Duration

Due to

Due to

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)
(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

SUPPLEMENTARY

31123