

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph, Mo
(c) Name of hospital or institution Margaret Little Nursing Home
(d) Length of stay: In hospital or institution 1 month 4
In this community 4 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County DeKalb
(c) City or town Union Star, Mo
(d) Street No. 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

James Lee Miller

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Elizabeth B. Miller 6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased Mar. 26, 1852
(Month) (Day) (Year)

8. AGE: Years 92 Months 11 Days 3 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business at home

12. Name James Lee Miller

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

14. Maiden name Mary Jane Crowson

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

16. (a) Informant A. Roscoe Miller

(b) Address 2231 Felix St. Joseph, Mo

17. (a) Removal (b) Date thereof Mar. 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Star, Mo

18. (a) Signature of funeral director Lucile M. Wilson

(b) Address King City, Mo

19. (a) 3-8-45 (b) Delbert D. Pugh
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 1 year 1945 hour 8 minute A.M.

21. I hereby certify that I attended the deceased from Dec 10, 1944 to Mar 1, 1945
that I last saw him alive on Feb 28, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arterio Sclerosis

Other conditions g3a!
(Includes pregnancy within 3 months of death)

Major findings: g3a!
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 J. R. Bell (M. D. or other) MD
Address 2015 Brown, St. Joseph, Mo signed 3-1-45

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

MOTHER FATHER

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 *Lucile M. Wilson*.....

Licensed Embalmer No. *2830*.....

P. O. Address *King City 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.