

S. No. 2  
1-5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

2530

FILED JAN 28 1946 STANDARD CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 4130

State File No. ....

Registrar's No. 2

1. PLACE OF DEATH:

(a) County... CRAWFORD

(b) or town... BOURBON

(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: 18 Years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State... Missouri (b) County... Crawford 28

(c) City or town... Bourbon 0

(d) Street No. .... (If rural, give location) 0

(e) Citizen of foreign country? .... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME WILLIAM GRAY MILLER

3. (b) If veteran, name war No. 1

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3 year 1946 hour 7 minute 50 P.M.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife EDNA MILLER

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased OCTOBER 8, 6, 1862 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 22 1945 to Jan 3 1946

that I last saw him alive on Jan 3 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

8. AGE:	Years	Months	Days	If less than one day
	83	2	27	hr. min.

Due to .....

Due to .....

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

10. Usual occupation Blacksmith

11. Industry or business Blacksmithing

12. Name William Miller

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

14. Maiden name ELLEN GRAY

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

16. (a) Informant Mrs. Edna Miller

(b) Address Bourbon, Missouri.

17. (a) Burial (b) Date thereof Jan 5, 1946 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bourbon, Mo.

18. (a) Signature of funeral director Wm. P. Hoffman

(b) Address Sullivan, Missouri

19. (a) 1-5-46 (b) E. E. Long (Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Means of injury

23. Signature (M. D. or other) Sullivan, Mo. Date signed 1/4/46

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

MOTHER FATHER

107  
1-1  
X 10

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**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 *Edgar W. Laffoon*

Licensed Embalmer No. *3394*

P. O. Address *Sullivan 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Feb

20

Registration District No.

87

Primary Registration District No.

4150

Registrar's No.

## 1. PLACE OF DEATH:

- (a) County Crawford Benton  
 (b) City or town \_\_\_\_\_  
 (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)

## 3. (a) PRINT FULL NAME

Wm Shay 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 \_\_\_\_\_

7. Birth date of deceased
- Oct 6

(Month)

(Day)

(Year)

8. AGE: Years
- 83

Months \_\_\_\_\_

Days \_\_\_\_\_

(If less than one day)

hr. min.

9. Birthplace
- Ill.

(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) \_\_\_\_\_ (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)

## 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 \_\_\_\_\_
- 
- year
- 1946
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

- Immediate cause of death \_\_\_\_\_
- 
- Duration \_\_\_\_\_

- Due to
- Primary lesion
- 
- probable in
- 
- stomach or liver.

- Due to \_\_\_\_\_

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

- Major findings:
- 
- Of operations \_\_\_\_\_

- Of autopsy
- H&E

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
- [Signature]
- (M. D. or other) \_\_\_\_\_

- Address
- [Address]
- Date signed
- 2/11/46

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

SUPPLEMENTARY

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

2930