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5-17-39  
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23349  
23344

State File No. ....

Registrar's No. 635

FILED AUG 15 1946  
Registration District No. 1228

Primary Registration District No. 5466

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town RURAL, N. CAMPBELL TWP.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Greene County Farm 5  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1411 E. McDaniel  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME HARLEY JASPER MILES

20. DATE OF DEATH: Month July day 31  
year 1946 hour 8 minute 45 P. M.

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

21. I hereby certify that I attended the deceased from 7-20 1944 to 7-31 1946  
that I last saw him alive on 7-31 1946  
and that death occurred on the date and hour stated above.

4. Sex male 0 5. Color or race white 6. (a) Single, widowed, married, divorced married

Immediate cause of death.....  
Duration.....

6. (b) Name of husband or wife Bessie Miles (wife) 6. (c) Age of husband or wife if alive UNK. years

Broncho pneumonia  
Cerebral Spinal Lues.

7. Birth date of deceased November 10, 1892  
(Month) (Day) (Year)

Due to.....

8. AGE: Years 53 Months 8 Days 21 If less than one day hr. min.

Due to.....

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

Other conditions Optic atrophy with blindness.  
(Include pregnancy within 2 months of death)

10. Usual occupation Butcher (retired)

Major findings: Of operations.....  
Of autopsy.....  
PHYSICIAN.....  
Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name John W. Miles

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

14. Maiden name Minnie Stevens

15. Birthplace UNK. Kansas / (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Miles

(b) Address 1411 E. McDaniel, Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/46 (Month) (Day) (Year)

(c) Place: burial or cremation HAZELWOOD CEMETERY

18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME

(b) Address 534 St. Louis St., Springfield, Mo.

19. (a) 8-2-46 (Date received local registrar) (b) S. W. S. Handy (Registrar's Signature)

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 plant) (b) Means of injury.....

23. Signature James R. Cross (M. D. or other) MD.

Address Springfield, Mo. Date signed 8-2-46

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

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22230

111

44

MAY 13 1947

MAY 13 1947

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 Frank Gable  
Licensed Embalmer No. 4140  
P. O. Address Springfield, 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.

X