

V. S. No. 2
 OOM-5-43
 Rev. 5-17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

43987

State File No. _____

FILED DEC 22 1947

Registration District No. 348

Primary Registration District No. 4572

Registrar's No. 34

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

1. PLACE OF DEATH:
 (a) County Sullivan
 (b) City or town Newtown
(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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Sullivan 105
 (c) City or town Newtown
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Eli Grant Miller
 3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 3
 year 1947 hour 9 05 AM minute _____ M.
 21. I hereby certify that I attended the deceased from 1946 to 1947
 _____, 19____, to _____, 19____;
 that I last saw him alive on Nov. 25th, 1947;
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Minnie Miller 6. (c) Age of husband or wife if alive 80 years
 7. Birth date of deceased: Jan. 6 1865
(Month) (Day) (Year)

Immediate cause of death Cardio-vascular-renal disease, with special reference to the degree of kidney involvement.
 Due to Secondary anemia.

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>10</u>	<u>27</u>	_____ hr. _____ min.

Due to _____
 Other conditions none
(Include pregnancy within 3 months of death)

9. Birthplace Sullivan Co. Mo.
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired Farmer

Major findings:
 Of operations _____
 Of autopsy none
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 MOTHER FATHER { 12. Name Rufus Miller
 13. Birthplace _____ Ind. /
(City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Smith
 15. Birthplace _____ Ind. /
(City, town, or county) (State or foreign country)

16. (a) Informant Glen Miller
 (b) Address Harris, Mo.
 17. (a) Burial (b) Date thereof 12-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Brantly Ceme.

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 _____

18. (a) Signature of funeral director Martin Funeral Home
 (b) Address Princeton, Mo.
 19. (a) Dec 16-47 (b) Greta Caldwell
(Date received local registrar) (Registrar's signature)

23. Signature AS Bristow (M. D. or other) MD.
 Address Bristow Bldg Date signed 12/2/47
Princeton, Mo

RECEIVED
District Health Officer No. 10
District File Number 12-47-1772
Date Filed - DEC-1-9-1947

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 H. Swan Martin.....

Licensed Embalmer No. 3760.....

P. O. Address Quinton, Md.....

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.