

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

5652

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. St. Joseph's Hospital) St. _____ Ward _____

File No. _____
Registered No. 743
St. _____ Ward _____

2. FULL NAME John Willis Miller

(a) Residence No. 1315 South Paseo Place Ward _____
(Usual place of abode) Mary Geo in K.C. no. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Grace A. Miller</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 30, 1874</u>				
7. AGE	YEARS <u>56</u>	MONTHS <u>8</u>	DAYS <u>15</u>	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Dry Goods Store</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Dry Goods Store</u> (c) Name of employer <u>Emercy Park Shop Co.</u>				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>				
PARENTS	10. NAME OF FATHER <u>John Miller</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>			
	12. MAIDEN NAME OF MOTHER <u>Anna Byrne</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 15 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 1931, to Feb-15, 1931, that I last saw him alive on Feb 15, 1931, and that death occurred, on the date stated above, at 11:15 Am

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute meningitis from a chronic suppurative Right Ear - 4 months (duration) yrs. 4 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Chronic suppurative Right Ear (duration) yrs. 4 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED here in K.C. mo

IF NOT AT PLACE OF DEATH DID AN OPERATION PRECEDE DEATH? no DATE OF none done

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? yes (Signed) Hal Foster, M. D.

Feb-16 1931 (Address) 1426 Professional

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

St. Washington Cem. 2-17 1931

20. UNDERTAKER ADDRESS 3285

Shive + McColure Gilham Place

14. INFORMANT Mrs. Geo P. Reichel
(Address) 3415 Coleman Road
15. FILED 2/16 1931 M. M. Crowe
REGISTRAR

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Professional Reg.

HA-3093

2-4