

REC'D MAR 9 1939

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

5505

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Kan Primary Registration District No. 1092
(c) City Kansas City (d) Street No. R C Gen Hosp Registered No. 704
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Jacob Miller St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)
2914 Sales

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sela Miller
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26 1891
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 47 4 20
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri13. NAME Chas E Miller14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri17. INFORMANT (NAME) (ADDRESS) Rec'd Clerk R C Gen Hosp18. BURIAL, CREMATION, OR REMOVAL PLACE Greenwood DATE Feb 17 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. J. Foster 91808 W. 11th St. Kansas City20. FILED 1/18/39 M. W. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 16 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1939 to Feb 16 1939
I last saw alive on Feb 16 1939 Death is said to have occurred on the date stated above, at 2:35 PM
The principal cause of death and related causes of importance were as follows:

Chronic vascular Date of onset
Nephritis; Hypertensive
phased Heart 131
Other contributory causes of importance:

Pulmonary Edema

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) O. D. De Maria M. D.
(Address) Rec'd Clerk R C Gen Hosp

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.