No. 2
11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1940 399

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 30998

Registrar's No. 3561

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

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days (Specify whether
In this community Unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. Little Sisters of the Poor
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME JOSEPH MILLER

3. (b) If veteran, name war Unk.

3. (c) Social Security No. Unk.

4. Sex M.

5. Color or race W.

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased March (Month) 15th, (Day) 1873 (Year)

8. AGE: Years 67 Months 5 Days 25 If less than one day hr. min.

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

10. Usual occupation None listed

11. Industry or business

FATHER
12. Name Frank Miller
13. Birthplace (City, town, or county) Russia (State or foreign country)

MOTHER
14. Maiden name Margaret Volt
15. Birthplace (City, town, or county) Russia (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K.C. Gen. Hospital, K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (Month) 12 (Day) 40 (Year)

(c) Place: burial or cremation Mt. Calvary

18. (a) Signature of funeral director Quirk & [illegible]

(b) Address 20 W Linwood

19. (a) Sept. 11, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10th year 1940 hour 7 minute 52 A. M.

21. I hereby certify that I attended the deceased from Aug. 22nd, 1940, to Sept. 10th 1940, 19 ; that I last saw him alive on Sept. 10th, 1940, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic uremia	
n m n	
Due to 1070	
Due to	
Other conditions Hypostatic bronchopneumonia (Include pregnancy within 3 months of death)	
n. m. O.	
Major findings: Of operations	
Of autopsy None	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Drury R. Shore (M. D. or other)

Address Med. Dir. K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Harold Perry

Licensed Embalmer No. 4097

P. O. Address K C 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, above space should be left blank.