

No. 2
4-13-40
5-17-39
I X23159

~~NOV 12 1940~~ 399
Registration District No.

Primary Registration District No. 1002

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: 609 Cambridge 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No
(Specify whether)

In this community 14 yrs.
years, months or days

3. (a) PRINT FULL NAME MARTHA E. MILLER

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Walter C. Miller

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased 1/3/1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>9</u>	<u>12</u>	<u>0</u> hr. <u>0</u> min.

9. Birthplace Barry County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business No

MOTHER FATHER { 12. Name xx Stever

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Walter C. Miller

(b) Address 609 Cambridge

17. (a) Burial (b) Date thereof 10/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director John P. Sheil

(b) Address 6606 Indep. Ave., K. C. Mo.

19. 10-17-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 609 Cambridge
(If rural, give location)

(e) If foreign born, how long in U. S. A.? no years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 15 year 1940
hour 6:30 minute 0 M.

21. I hereby certify that I attended the deceased from 6:30 to 6:30 1940

that I last saw the deceased on 10-15-40 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial infarction

rupture of the heart

acute myocardial infarction

acute coronary occlusion

Major findings: 9:00
Of operations Yes

Of autopsy Yes

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) Means of injury 5

23. Signature M. M. Brown (M. D. or other)

Address K.C. Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, fact should be so stated above.