No. 2
1-4-41
17-39
X26390

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

FILLED JUN 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17443

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2105

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 No. 1 ( )
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community 14 YEARS. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4714 Summit 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ethel M. Miller

3. (b) If veteran, name war No

3. (c) Social Security No. NO

4. Sex FE/

5. Color or race Wh

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

6. (b) Name of husband or wife DAN

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased JAN (Month) 9 (Day) 1895 (Year)

8. AGE: Years 46 Months 4 Days 17 If less than one day hr. min.

9. Birthplace WESTON (City, town, or county) O MO (State or foreign country)

10. Usual occupation HOUSEWIFE.

11. Industry or business

FATHER
12. Name JOHN M. MITCHELL.
13. Birthplace WESTON (City, town, or county) O MO (State or foreign country)

MOTHER
14. Maiden name LYDIA WALLACE
15. Birthplace WESTON (City, town, or county) O MO (State or foreign country)

16. (a) Informant Mrs. Florence Lober
(b) Address Dearborn Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-41 (Month) (Day) (Year)
(c) Place: burial or cremation Weston Mo

18. (a) Signature of funeral director Howard I. Roe
(b) Address 3146 Main

19. (a) May 29, 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26th
year 1941 hour 7 minute 40 P. M.

21. I hereby certify that I attended the deceased from May 21st 1941 to May 26th 1941;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis and tuberculosis of spine

Due to 13 B

Due to 13 B

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None
None

Duration

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? X
(Specify type of place)
While at work? (e) Means of injury

23. Signature Drury R. Thorn (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 Howard F. Roe

Licensed Embalmer No. 2748

P. O. Address 1324 E. 36.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.