

Registration District No. 154

Primary Registration District No. 5575

Registrar's No. 59

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Missouri, Kansas City
(c) Name of hospital or institution: Kernodle's Lake 3 (Rural)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Lifetime years, months or days

3. (a) PRINT FULL NAME Miss Alice Mae Miller

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 21 1934
(Month) (Day) (Year)

8. AGE: Years 8 Months 11 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Scholar

11. Industry or business Greenwood School

12. Name Herbert P. Miller
13. Birthplace Warren Pennsylvania
14. Maiden name Ethel McCombs
15. Birthplace Stephens County Kansas

16. (a) Informant Mr. Herbert P. Miller

(b) Address 2528 Bellefontaine

17. (a) Burial (b) Date thereof Aug. 19, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director D. E. Newcomer

(b) Address 1401 Brush Creek Blvd.

19. (a) 8/16-43 (b) Dr. Annie G. Hedges
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 2528 Bellefontaine
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8
year 1943 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____ to _____
Deputy Coroner
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Acute pulmonary edema
Strawning

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Inspection and history

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 048
(b) Date of occurrence August 8, 1943
(c) Where did injury occur? Rural Jackson Mo
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? No (Specify type of place) _____
(e) Means of injury Strawning
23. Signature D. E. Newcomer (M. D. or other) _____
Address 2315 M. Hwy Date signed 8/19/43

1152

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

MOTHER FATHER

110 City of Haverhill
Dr. Hedges

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 Ernie W. Albourn
Licensed Embalmer No. 3506
P. O. Address Kenn

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson (Rural)
 (b) City or town Washington Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Alice Mae Miller
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1943 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Aug 21 (Month) (Day) (Year)

8. AGE: Years 8 Months _____ Days _____ If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8/16-43 (b) Dr. Annie G. Hedges
 (Date received local registrar) (Registrar's signature)

Due to _____
 Due to _____
 Other conditions: _____ (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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?
 _____ (Specify type of place)
 While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

28479