

UNITED STATES DEPARTMENT OF THE CENSUS
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3881**

FILED OCT 9 1944
Registration District No. 197

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:
1907 East 16th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days)

3. (a) PRINT FULL NAME Rosa Bell Miles

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife Joseph Miles

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

7. Birth date of deceased August 25, 1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>1</u>	<u>0</u>	hr. min.

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

10. Usual occupation At Home

11. Industry or business None

12. Name John Frazier

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

14. Maiden name Unknown

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

16. (a) Informant Mr. Edwin Miles

(b) Address 2410 Woodland

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/27/44
(Month) (Day) (Year)

(c) Place: burial or cremation Blackburn, Missouri

18. (a) Signature of funeral director Matthew Bras

(b) Address 1729 Lydia Avenue

19. (a) 9-26-44 (Date received local Registrar) (b) D. E. Brown (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. 1907 East 16th Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25 Monday
year 1944 hour 3:45 minutes P. M.

21. I hereby certify that I attended the deceased from Sept 19 1944 to Sept 25 1944
that I last saw her alive on Sept 25 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia
Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions 83 a
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? _____

23. Signature J. M. Brown (M. D. or other)
While at work? _____ (Specify type of place) (e) Means of injury _____

Address 1705 E 12 Date signed Sept 26 44

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.....

J J Manlove

Licensed Embalmer No.....

3994

P. O. Address.....

2503 Highland

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.