

FILED AUG 4 1951

STANDARD CERTIFICATE OF DEATH

State File No. **23154**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2906

1. PLACE OF DEATH
 a. COUNTY Jackson
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City
 c. LENGTH OF STAY (In this place) 5 days
 d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital of institution, give street address or location) Childrens Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
 a. STATE Kansas b. COUNTY Wyandotte
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City 8150
 d. STREET ADDRESS (If rural, give location) 715 Cheyenne 8

3. NAME OF DECEASED
 a. (First) Paula b. (Middle) Diana c. (Last) Miles
 (Type or Print) Paula Diana Miles
4. DATE OF DEATH (Month) (Day) (Year) July 7 1951

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) No **8. DATE OF BIRTH** Mar. 29-1951
9. AGE (In years last birthday) 1 **10. MONTHS** 3 **11. DAYS** 8 **12. HOURS** 0 **13. MIN.** 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None **10b. KIND OF BUSINESS OR INDUSTRY** None **11. BIRTHPLACE** (State or foreign country) Kansas City Kans **12. CITIZEN OF WHAT COUNTRY?** USA

13a. FATHER'S NAME John Miles **13b. MOTHER'S MAIDEN NAME** Mary Wilson **14. NAME OF HUSBAND OR WIFE** None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) **16. SOCIAL SECURITY NO.** _____ **17. INFORMANT'S SIGNATURE OR NAME** John Miles (Father) **ADDRESS** 715 Cheyenne K.C. Kan

18. CAUSE OF DEATH
 Enter only one cause per line for (a), (b), and (c)
 *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition
ANTECEDENT CAUSES
 DUE TO (b) Malnutrition
 DUE TO (c) unknown
II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death. Candida Albicans Infection of Pharynx

INTERVAL BETWEEN ONSET AND DEATH
1720

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION** _____ **20. AUTOPSY?** YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ **21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)** _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ **21e. INJURY OCCURRED** WHILE AT WORK NOT WHILE AT WORK **21f. HOW DID INJURY OCCUR?** _____

22. I hereby certify that I attended the deceased from July 5, 1951, to July 7, 1951, that I last saw the deceased alive on July 7, 1951, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE Richard C. Schaffer MD (Doctor or title) **23b. ADDRESS** St. Lukes Hospital **23c. DATE SIGNED** 7-7-51

24a. BURIAL, CREMATION, REMOVAL (Specify) burial **24b. DATE** 7-9-1951 **24c. NAME OF CEMETERY OR CREMATORY** Maple Hill **24d. LOCATION** (City, town, or county) (State) Kansas City Kansas

DATE REC'D BY LOCAL REG. 7-9-51 **REGISTRAR'S SIGNATURE** Geraldine Holmes **25. FUNERAL DIRECTOR'S SIGNATURE** Kate Daniels **ADDRESS** Parish 526 Minnie

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed.....

W. L. Ward

Licensed Embalmer No. 3991

P. O. Address 308 E. 168

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.