

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-023275

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3434

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JUL 16 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

By Affiant of W. H. Miller

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH e. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>20 years</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) On Side HOSPITAL OR INSTITUTION <b>Walk, 1024 Locust</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1016 Locust</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANK W. MILLER</b>			4. DATE OF DEATH Month Day Year <b>June 28 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1876</b>
9. AGE (last birthday) <b>86 years</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <b>Retail Merchant, ret</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Luggage</b>	11. BIRTHPLACE (City and state or country) <b>Decatur Illinois</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. Miller</b>	
13b. MOTHER'S MAIDEN NAME <b>Catherine Bickes</b>		14. NAME OF HUSBAND OR WIFE <b>Emma M. Miller, dec</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>John J. Miller, Seattle, Wash.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>massive I.D. hemorrhage 9/18/64, apparently from gastric ulcer</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>5-8-61</b> to <b>6-28-62</b> and last saw him alive on <b>4/30-62</b> Death occurred at <b>5 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>William H. Miller M.D.</b>		22b. ADDRESS <b>3626 Indy. Ave Kansas City 24, Mo</b>	22c. DATE SIGNED <b>6/29/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-2-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>
24. FUNERAL DIRECTOR <b>Wagner Funeral Home, K. C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-29-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth V Long</b>

Dr. Arlison H. Miller  
3626 Sandpiper Lane  
B-1-2800  
after 12.00 Noon

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Alvin R. Haenackild

Licensed Embalmer No. 4159

P. O. Address H. C. MD

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.