

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034900

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4906 STATE FILE NUMBER

FILED OCT 8 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 20 YES	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8009 Brooklyn Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Claude Middle H Last Miley			4. DATE OF DEATH Month September Day 24th Year 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-21-04
9. AGE (last birthday) 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSISTANT MANAGER	10b. KIND OF BUSINESS OR INDUSTRY INS. CO. METROPOLITAN LIFE
11. BIRTHPLACE (City and state or country) BASTROP, TEXAS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WILLIAM J. MILEY		13b. MOTHER'S MAIDEN NAME FRANCES GREEN	
14. NAME OF HUSBAND OR WIFE HELEN LOUISE MILEY		17. INFORMANT Address MR. SIDNEY T. MILEY 8009 BROOKLYN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. INTERVAL BETWEEN ONSET AND DEATH 3 days
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia			
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) Post-encephalitic Parkinson's Disease			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 checked="" type="checkbox"/> NO <input 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 1952 to Sept 24, 1962 and last saw him alive on Sept 24, 1962 Death occurred at 6:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE JACK W. WOLF (Degree or title) M.D.		22b. ADDRESS 409 E. 65 ST Kansas City, Mo.	22c. DATE SIGNED 9/25/62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 9-26-62	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY OKLAHOMA CITY, OKLAHOMA	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS MELBOY-MCGILLEY-EYAR WOODLAND - LINWOOD		25. DATE RECD. BY LOCAL REG. 9-25-62	26. REGISTRAR'S SIGNATURE Ruth Long

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JACK W. WOLF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59
1
2 **3968**
3
4 **0**
5 **2**
6
7 **1**
8 **1**
9 **491X**
10
11
12 **61-0**
13

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 James E. Hackleman

Licensed Embalmer No. 4573

P. O. Address K. C. Moore

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.