

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034902

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4793

FILED SEP 28 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

H.A. Underwood

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 75 Years | 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 St. Mary's Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1915 Hardesty Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED First Middle Last Mrs. Betty Miller | | | 4. DATE OF DEATH Month Day Year September 16, 1962 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8/2/71 |
| 9. AGE (last birthday) 91 Yrs. | | 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) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY - - - - | 11. BIRTHPLACE (City and state or country) Stockholm, Sweden U. S. A. |
| 12. CITIZEN OF WHAT COUNTRY U. S. A. | | 13a. FATHER'S NAME Olaf Munson | 13b. MOTHER'S MAIDEN NAME Unknown |
| 14. NAME OF HUSBAND OR WIFE Thomas A. Miller | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT 2509 W. 84th St., Leawood, Kansas Mrs. Elizabeth Martin | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation | | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) _____ | | | |
| DUE TO (c) Arteriosclerotic Cardiovascular Disease | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Lung | | | 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 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 8-5-62 to 9-16-62 and last saw her ^{her} _{him} live on 9-15-62 Death occurred at 2:26 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE H. A. Underwood, M.D. (Degree or title) | | 22b. ADDRESS 5100 E 24th K.C. Mo. | 22c. DATE SIGNED 9/17/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Sept. 18, '62 | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery | 23d. LOCATION (City, town, or county) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS D. W. NEWCOMER'S SONS 1331 Brush Creek Blvd. K.C. Mo. | | 25. DATE RECD. BY LOCAL REG. 9-18-62 | 26. REGISTRAR'S SIGNATURE Ruth Long |

Dr Henry Brown Undertaker
5100 East 24th Street
R: 30-0:00

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 Thomas W. Brown

Licensed Embalmer No. 4889

P. O. Address Lathrop Mo.

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.