

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

10095

1. PLACE OF DEATH

County Jackson Registration District No. 303 File No. _____
 Township Kaw Primary Registration District _____ Registered No. _____
 City Kansas City (No. Sweet's Hospital) Ward _____

2. FULL NAME

James Prville Miller
 (a) Residence No. Long Lane, Missouri Ward _____ (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. 1 mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 9, 1901

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
17 | 11 | 19 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Dallas Co. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Thomas Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Jumella Hamilton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Jennie Benton
 (Address) Long Lane, Mo.

15. FILED 5/28/19 Ada Cross REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 28 1919

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1919, to March 28, 1919 that I last saw him alive on March 28, 1919, and that death occurred, on the date stated above, at 1:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxial
Pneumonia

(duration) yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Infection
 (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
 (Signed) Carl Landgren, M.D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Long Lane, Mo. DATE OF BURIAL March 28 1919

20. UNDERTAKER St. Vincent's Socy ADDRESS 2111 E 9th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

