

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

Do not use this space.

17434

1. PLACE OF DEATH

County Jackson Registration District No. 39 File No. 2418
 Township Kaw Primary Registration District No. 100 Registered No. 2418
 City Kaysor (No. 100) St. Mo. Ward 4

2. FULL NAME

Angelma Frances Miles
 (a) Residence. No. 1737 E. 11th St. 4 Ward. 4
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4 **4. COLOR OR RACE** red **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS 68 MONTHS _____ DAYS _____ **IF LESS than 1 day,** hrs. _____ min. _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Domestic
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Thomas X. Spruce 704 E 13th St. Ontario Mo

15. FILED 6/3, 1928 M. M. Crowe REGISTRAR Assn

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-30 1928

17. I HEREBY CERTIFY That I attended deceased from 5-27, 1928 to 5-30, 1928 that I last saw him alive on 5-30, 1928 and that death occurred, on the date stated above, at 8:30 AM

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Apoplexy due to hyper-tension
 (duration) yrs. 102 mos. 82K da. _____
CONTRIBUTORY (SECONDARY) 7/401 (duration) yrs. _____ mos. _____ da. _____

18. WHERE WAS DISEASE CONTRACTED 1213 E-11th
 IF NOT AT PLACE OF DEATH, no DATE OF _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Chinical Pathology Investigator to 6/3, 1928 (Address) Fed City Hosp.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hope Ark **DATE OF BURIAL** 6-9 1928

20. UNDERTAKER Julius M. Ficklin **ADDRESS** City

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.

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