

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

Do not use this space.

30448

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_

Township J. Raw Primary Registration District No. \_\_\_\_\_

City J. C. Mo. (No. 2744 Spruce St. \_\_\_\_\_ Ward) \_\_\_\_\_

File No. 2206

Registered No. \_\_\_\_\_

**2. FULL NAME**

Mary Ellen Miller

(a) Residence. No. 2744 Spruce St., 12 Ward.  
(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. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

F

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

married

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

John Miller

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

Nov-18-1891

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

36

9

17

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Housewife

(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)

Mo.

**10. NAME OF FATHER**

John Anderson

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Mo.

**12. MAIDEN NAME OF MOTHER**

Margaret Green

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Mo.

**14. INFORMANT**

John Miller  
(Address) 2744 Spruce Ad.

**15. FILED**

9/6 28 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

Sept-5-1928

**17. I HEREBY CERTIFY**, That I attended deceased from Sept 4, 1928, to Sept 5, 1928, that I last saw her alive on Sept 5, 1928, and that death occurred, on the date stated above, at 3:40 Am.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Diabetes mellitus

**CONTRIBUTORY (SECONDARY)**

Pyelonephritis

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH?** No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory & Clinical

(Signed) J. M. Denslow, M. D.

9/5, 1928 (Address) 838 N. 44th St.

\*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**

**DATE OF BURIAL**

Forest Hill

Sept 7 1928

**20. UNDERTAKER**

Mrs. C. L. Foster

**ADDRESS**

R. C. Mo.

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.

839 Argyle Bldg

Vic. 7474

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