

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

Do not use this space.

37130

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Law Primary Registration District No. 1002
 City Kansas City (No. 701, Pennsylvania) St. 1st Ward

File No. _____
 Registered No. 4781
 St. 1st Ward

2. FULL NAME

Lillian Miles
 (a) Residence. No. 701 Pennsylvania St., 1st 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 Female 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 20-1894

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
37 ~~38~~ 8 4

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Robert Johnson

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

12. MAIDEN NAME OF MOTHER Helen (Quinterous)

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

14. INFORMANT Carl Johnson (Address) 701 Pennsylvania, K.C. Mo

15. FILED 17, 19 28 M.M. Terone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 24 19 28

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 19 28, to Nov 24, 19 28 that I last saw her alive on Nov 24, 19 28, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchitis Pneumonia

CONTRIBUTORY (SECONDARY) 1000 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical (Signed) Ch. Alexander M. D.

11-24, 19 28 (Address) 1512 N. 5th St., K.C. Mo.

*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 West Lawn DATE OF BURIAL Nov 28 19 28

20. UNDERTAKER K.C. Emb & Basket Co ADDRESS 470 State ave K.C. Kansas

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.

MADE PERMANENT, WITH UNFADING INK—THIS IS A PERMANENT RECORD

