

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

Do not use this space.

1931  
14889

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Law Primary Registration District No. 105  
 City Kansas City (No. Kansas City Gen Hosp St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

(a) Residence, No. 610 E 8th St. 1 Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 3 - 1875</u>		
7. AGE	YEARS	MONTHS
<u>53</u>	<u>54</u>	<u>9</u>
	DAYS	IF LESS than 1 day, hrs. or min.
	<u>21</u>	

**B. OCCUPATION OF DECEASED**

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

(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) Nebraska

**PARENTS**

10. NAME OF FATHER Joe Miller

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

12. MAIDEN NAME OF MOTHER Mary Hayden

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

14. INFORMANT (Address) Re word clerk Kansas City Gen Hosp

15. FILED 4/30-29 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-24 1929

17. I HEREBY CERTIFY, That I attended deceased from 4-22 1929 to 4-24 1929 that I last saw him alive on 4-24 1929 and that death occurred, on the date stated above, at 2:35 P.M.

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

Abscess of lung  
114 B  
36  
 (duration) 3 yrs. mos. ds.

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

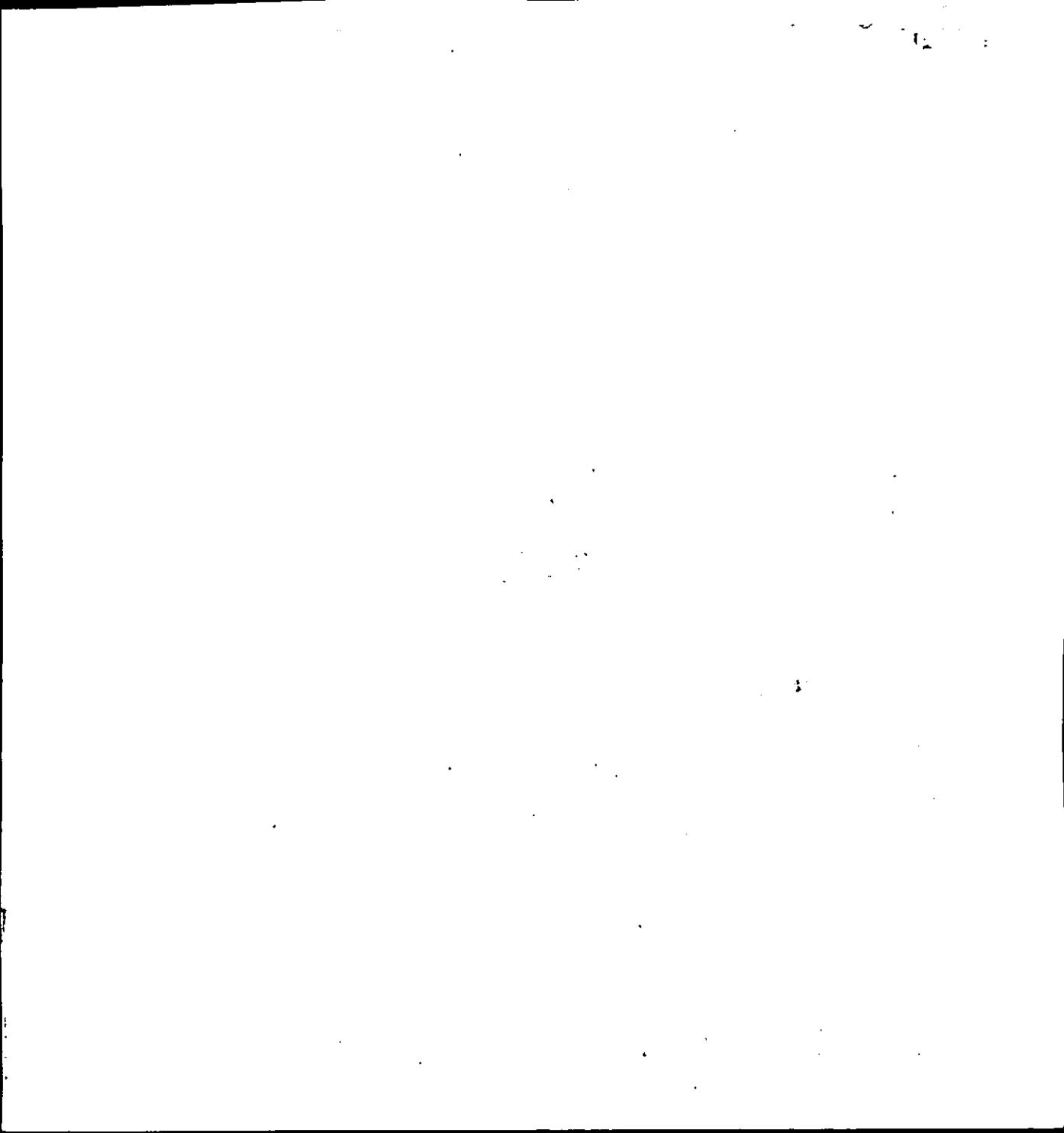
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clin + Lab Findings  
 (Signed) P. O. Williams M. D.  
4-24-1929 (Address) Supt KC Gen 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 Memorial Park DATE OF BURIAL 4-26-29

20. UNDERTAKER O. D. Mark ADDRESS 1910 E 15th



1101 Stearns.

You may have a supplemental record  
on this case which states, pulmonary  
tuberculosis, as the copy in this office  
shows that. However that is not  
correct as the hospital has a  
final diagnosis of non-tuberculous.

M. M. Crowe

1022.1.1.1

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County \_\_\_\_\_ Registration District No. 399 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1002 Registered No. 1934  
 City R. City (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward)

**2. FULL NAME**

Archie Miller  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(For the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 4/25, 1929 M. M. Brown REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/24 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Abstract of history  
mixed infection, staphylococci predom-  
inating.

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

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

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? 1

WHAT TEST CONFIRMED DIAGNOSIS (Signed) P. Williams, M. D.  
 . 19 (Address) San Vapst R. C. W.

\*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 19\_\_\_\_

20. UNDERTAKER ADDRESS

REGISARS A NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRINTED

SUPPLEMENTARY

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