

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

Do not use this space.

37460

1. PLACE OF DEATH

County.....Jackson.
Township.....Kaw.
City.....Kansas City (No. 2710 Madison.)

Registration District No.....
Primary Registration District No.....

File No.....
Registered No. 4930
St..... Ward)

2. FULL NAME Lois Lenore Miller.

(a) Residence. No. 2710 Madison. St. 3 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe. 4. COLOR OR RACE Wh. 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) Mch. 22, 1929.

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
8 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At-home
(b) General nature of industry, business, or establishment in which employed (or employer) ||
(c) Name of employer ||

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Arnold G. Miller

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

12. MAIDEN NAME OF MOTHER M.M. Nassimbene.

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

14. INFORMANT A.G. Miller.
(Address) 2710 Madison St.

15. FILED 11-29-29 M.M. Carver REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 29 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Nov 29, 1929 that I last saw him alive on Nov 29, 1929, and that death occurred, on the date stated above, at 8:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastro enteritis

11-29-29

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (SECONDARY) Preparatory 9 months

(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? usual tests

(Signed) Ward H. Leonard M.D.

11-30, 1929 (Address) 3232 Summit 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

Dec 2nd 29

20. UNDERTAKER

ADDRESS

H. W. Gates

K.C.Ks.

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.

