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

299

Do not use this space.

5049 706

1. PLACE OF DEATH
County: Jackson — Registration District No.: 1002 — File No.:
Township: Kansas — Primary Registration District No.: — Registered No.:
City: Kansas City (No.) General Hospital St. Ward)

2. FULL NAME: Laletha Miller
(a) Residence. No. 611 W. 8th St., 1 Ward. (If nonresident, give city or town and State)
(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: Female
4. COLOR OR RACE: Colored
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): Don't Know

7. AGE: Years: about 59 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

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): Don't Know

PARENTS
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

14. INFORMANT: Record Clerk
(Address): Gen. Hosp. #2 K.C. Mo

15. FILED 2/15, 19 30 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2-12 19 30

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 19 30, to Feb 12, 19 30 that I last saw h... alive on Feb 12, 19 30 and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
Hemiplegia
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY): 1290
(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?
(Signed) H. M. Smith, M. D.
2/12, 19 30 (Address) Gen. Hosp. #2 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: 2-15 19 30

20. UNDERTAKER: M. W. Kalber — ADDRESS: 1520 Oak St.

CAUSE OF DEATH in plain terms, so that any layman can understand it.