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

Do not use this space.

~~9072~~ 12756

File No. 1083

Registered No.

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Kaw — Primary Registration District No. 1002

City Kansas City (No. ~~3209 Broadway~~ St. Lukes Hospital St. Ward)

2. FULL NAME William J. Miller

(a) Residence. No. 3209 Broadway St., 5 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 8, 1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	42	1	9	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Proctor & Gamble Co.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Nebr.

PARENTS

10. NAME OF FATHER Unk---Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unk---Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Denmark

14. INFORMANT Mrs. Myrtle Miller

(Address) 3209 Broadway

FILED 4/17, 1930 M. M. Crosby Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 17, 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1930 — ~~10~~, to Apr. 16, 1930 that I last saw him alive on Apr. 16, 1930, and that death occurred, on the date stated above, at 1 45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute streptococcus Peritonitis
Hx R
4 6 5

1 29 Cirrhosis (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Stomach - with extension into Liver (duration) — yrs. — mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF April 15-1930

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Operation - autopsy - and Laboratory

(Signed) F. C. Lamar, M. D.

4/17, 1930 (Address) 915 Argyle Bldg

*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 Minneapolis, Minn — DATE OF BURIAL April 17, 30

20. UNDERTAKER R. V. Lindsey & Sons, Inc — ADDRESS Kansas City, Mo

ould be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.
o that it may be properly classified.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 1683

City K. C. (No. K. Dukes Hosp. St. ..... Ward)

2. FULL NAME William J. Miller

(a) Residence. No. 3209 Broadway St., ... 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 M | 4. COLOR OR RACE W | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Mar

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 8 1888

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
42	1	9	

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

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 4/17 19 30 M. M. Crowe
Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 17 19 30

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 19 30, to Apr 16, 19 30 that I last saw he alive on Apr 16, 19 30, and that death occurred, on the date stated above, at 1-45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....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? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. C. Ramsay M. D.

, 19 (Address) 915 Argyle Bldg.

*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 Apr 17 19 30

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 important.

SHALL BE FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PER LAW

5-12-54