

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

Do not use this space.

16317

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 40 East 55th)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2225 (Ward _____)

2. FULL NAME

GERTRUDE ANNA MILLER

(a) Residence. No. 40 East 55th St. 8 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. 8 How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 22, 1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>51</u>	<u>10</u>	<u>13</u>	

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) Missouri

10. NAME OF FATHER Henry L. Kraft

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

12. MAIDEN NAME OF MOTHER Clara V. Wagner

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

14. INFORMANT Dr. Hugh Miller
(Address) 40 East 55th St.

15. FILED 5/26, 1930 M. M. Brown
REGISTRAR Arer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1930

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930 to May 25, 1930 that I last saw her alive on May 25, 1930, and that death occurred, on the date stated above, at 8:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic endocarditis and myocarditis

(duration) 6 yrs. _____ mos. _____ da.
CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis
(duration) 2 yrs. _____ mos. _____ da.

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? Chiquial
(Signed) A. B. Jones, M. D.

May 26, 1930 (Address) 1079 Apple Blvd. E. 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 Mr. Mareah Cem DATE OF BURIAL 5-27 1930

20. UNDERTAKER Stine & Mc. Cure ADDRESS 35 Gilham Place

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.

1019 W. W. W. Bldg.

VI 4895

3-6 P.M.