

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

Do not use this space.

19433

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. 3781 Washington St.)

File No. _____
Registered No. 2427
St. _____ Ward)

2. FULL NAME

William Mason Miller

(a) Residence. No. 3781 Washington St. 5 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 male 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13, 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>63</u>	<u>10</u>	<u>27</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Salem
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER William Kincaid Miller

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

12. MAIDEN NAME OF MOTHER Cordelia Ank.

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

14. INFORMANT Mrs. William M. Miller
(Address) 3781 Washington St.

15. FILED 6/10/30 M. M. Crowe
REGISTRAR Assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1930

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 9, 1930 that I last saw him alive on June 9, 1930, and that death occurred, on the date stated above, at 7:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute subtotal obstruction (volvulus) with peritonitis
122 B
129 (duration) yrs. mos. 5 ds.
CONTRIBUTORY (SECONDARY) 118 B1 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) R. T. Blum, M. D.
6-10, 1930 (Address) Blum 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 Mr. Washington Cem. DATE OF BURIAL 6-17-1930
20. UNDERTAKER Blum + McQuinn ADDRESS 3235
Lillham 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.

64-1-1-27
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31

**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
Township *J City*
City *J City* (No.) St. Ward)

Registration District No. *399*
Primary Registration District No. *1002*

File No.
Registered No. *2427*
St. Ward)

2. FULL NAME

William Mason Miller

(a) Residence. No. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *M* (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 13-1869*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 - *27*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
(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 *6/10 30 M. M. Crook* 19... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 10 1930*

17. I HEREBY CERTIFY, that I attended deceased from to that I last saw him alive on 19....., and that death occurred, on the date last above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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)....., M. D. , 19 (Address)

*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

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-19433