

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

Do not use this space.

23179

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City

Registration District No. 099
Primary Registration District No. 1002
(No. Mercy Hospital)

File No. _____
Registered No. 3176 (Ward)

2. FULL NAME

James J. Smiles
(a) Residence, No. 205 Crescent St., _____ Ward.

(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 (write the word)

Single

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

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

June 27, 1930

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

—

1

4

8. OCCUPATION OF DECEASED

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

None

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Kansas City, Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Oliver Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Kansas

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Catherine Garbo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Kentucky

(STATE OR COUNTRY)

14. INFORMANT

Father Oliver Miller
(Address) 205 N. Crescent

15. FILED

8/1, 1930
M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

July 31, 1930

17.

I HEREBY CERTIFY, That I attended deceased from

7/15, 1930 to 7/31, 1930
that I last saw him alive on 7/31/30, 1930, and that death occurred, on the date stated above, at 7:00 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Birth Hemorrhage

1603

108

1074

(duration) 7 mos. 4 ds.
CONTRIBUTORY Pneumonia
(SECONDARY)

(duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Exam. Lab. - Autopsy

(Signed) Dr. Pakula M. D.

8/1, 1930 (Address) Mercy Hosp

*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

St. Marys

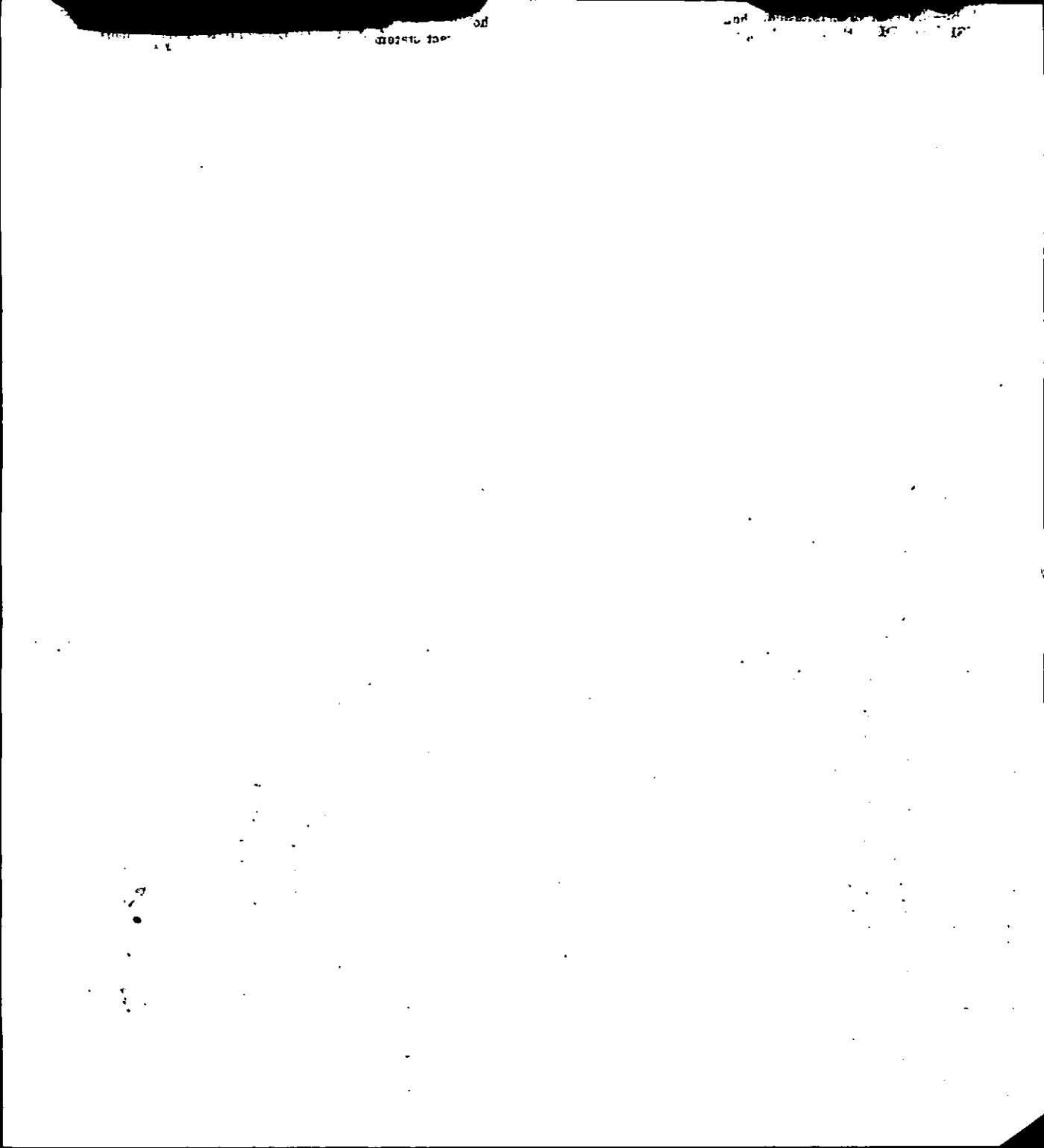
DATE OF BURIAL

8-1-1930

20. UNDERTAKER

Mrs. C. L. Fortney K. C. Mo.

N. B.—Every year information should be carefully supplied. AGE SHOWS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION OF DEATH.



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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. 3176
City..... (No. Therapy Hope) St. Ward.....

2. FULL NAME

James Miller
(a) Residence No. 201 Crescent St. Ward.....
(General 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(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....., 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31-1930

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Death Memorial
Instrumental? No history obtained
..... (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *Stetho medica Pneumonia*
Proneuro pneumonia (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)....., 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

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 terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTER A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-23179