

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

Do not use this space. ✓

32783

1. PLACE OF DEATH **U.S.V.Hosp.**

399

County **Jackson**

Registration District No. _____

File No. _____

Township **Law**

Primary Registration District No. **1002**

Registered No. **3993**

City **Kansas City, Mo.**

(No. **Unites States Veterans Hospital** St. _____ Ward)

2. FULL NAME **MILLER, Frank**

C-None SPBW

(a) Residence. No. **401 1/2 Independence Ave., St. /**

Wrt. 3rd Co; 3rd Bn; 164 DB

(Usual place of abode) **Kansas City, Missouri,** (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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 26, 1892**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 10 5

8. OCCUPATION OF DECEASED

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

(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) **Michigan**

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unknown**

14. INFORMANT **Hospital Records.**

(Address) **Kansas City, Mo**

15. FILED **10/1** 19 **30** **M. M. Cowie**

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **October 1, 1930**

17. I HEREBY CERTIFY, That I attended deceased from **September 29**, 19 **30**, to **October 1**, 19 **30**

that I last saw him alive on **October 1**, 19 **30**, and that death occurred, on the date stated above, at **3:15 A.M.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis, pulmonary, chronic, advanced

229
19

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) **Pneumothorax - spontaneous**
Diabetes Mellitus
Not known (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **Unknown**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Lab & X-ray**

(Signed) **J. E. CHAMBERS, M. D.**
U.S.V. Hospital, Kansas City, 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

Bark River, Michigan

DATE OF BURIAL

9/2/30 19

20. UNDERTAKER **Freeman Mortuary**

104 west 42nd. st.

ADDRESS

Kc Mo

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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

