

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

Do not use this space.

39296

1. PLACE OF DEATH

County Jackson Registration District No. 398
 Township Blue Primary Registration District No. 5554
 City Independence Mo. 1400 St. _____ Ward _____

File No. _____
 Registered No. 383

2. FULL NAME

Adaline Miller
 (a) Residence No. 8912 Thompson St. Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U.S., (if of foreign birth?) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 16 - 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 0 3

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Burlington, Iowa
 (STATE OR COUNTRY)

10. NAME OF FATHER William Hodges

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

12. MAIDEN NAME OF MOTHER Mary Steele

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

14. INFORMANT Mrs June Means
 (Address) 8912 Thompson Ave.

15. FILED 12-20, 1930 J. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-19 1930

17. I HEREBY CERTIFY, That I attended deceased from 11/17, 1930, to 12/19, 1930, that I last saw him alive on 12/19, 1930, and that death occurred, on the date stated above, at 12 noon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Fracture Hip
2. Rheumatoid
50
930 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Nephritis
 (duration) _____ yrs. _____ mos. _____ ds.

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? Clinical & Laboratory
 (Signed) Miller M. D.

DUG: 19 _____ (Address) 10307 Sadler Rd 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 MT. Washington DATE OF BURIAL 12/22 1930

20. UNDERTAKER Morton + Co ADDRESS Mo Ke 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.

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**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 Jackson
Township Bellevue
City (No.)

Registration District No. 398
Primary Registration District No. 5554

File No.
Registered No. 983
St. Ward

2. FULL NAME

Madeline Miller

(a) Residence (Usual place of abode) St. Ward.
(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 F RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word)

5A. IF MARRIED, WIDOWED, 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.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or artistic 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)

PARENTS

14. INFORMANT (Address)

15. FILED 2-6-31 F. R. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/19 19 31

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Fractured hip about 3 weeks
metastatic (chronic)
Carcinoma Metastases from
Breast. Fracture of shaft of
Right humerus.
CONTRIBUTORY (SECONDARY) Nephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAICTED IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE

19. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

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

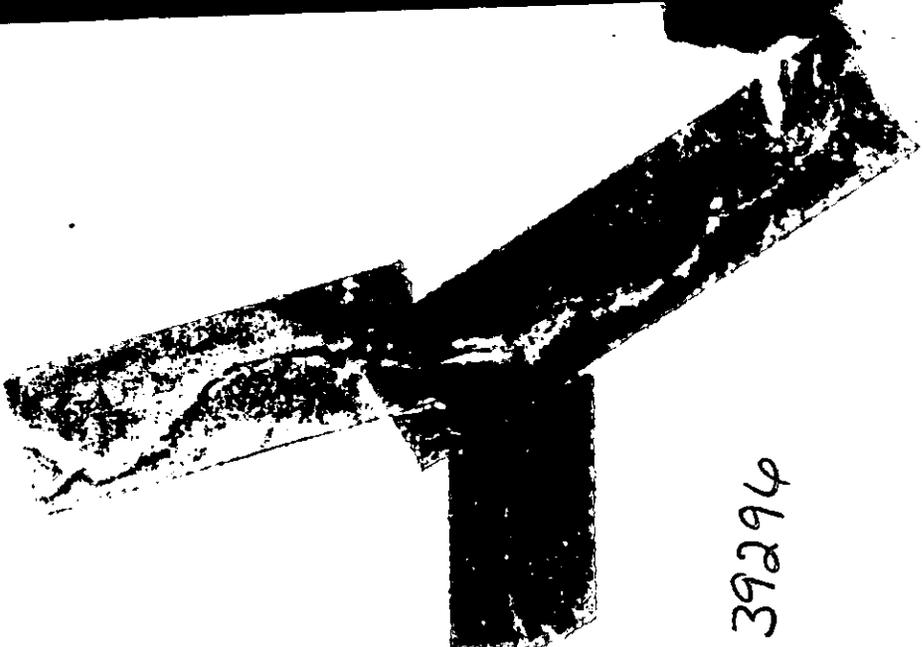
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully stated. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR THIS SUPPLEMENTARY.

SUPPLEMENTARY



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