

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

4883

**1. PLACE OF DEATH**

County Jackson Registration District No. 122  
 Township Keaw Primary Registration District No. 300  
 City Kansas City (No. Kansas City Gen Hosp) St.      Ward     

File No.       
 Registered No. 740  
 St.      Ward     

**2. FULL NAME**

John Miller  
 (a) Residence, No. 811 E. 12th St. 2 Ward       
 (Usual place of abode)  
 Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>    </u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 11 - 1882</u>		
7. AGE	YEARS <u>60</u>	MONTHS <u>0</u>
	DAYS <u>75</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as splaner, sawyer, bookkeeper, etc. <u>Fireman</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>181</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Wisconsin</u>	
	13. NAME <u>W. B. Miller</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Wisconsin</u>	
	15. MAIDEN NAME <u>Unknown</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
17. INFORMANT (ADDRESS) <u>R. C. Gen Hosp KC Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Deeds</u> DATE <u>2/23</u>		
19. UNDERTAKER (ADDRESS) <u>Lapetona</u>		
20. FILED <u>2/23</u> 19 <u>32</u> <u>32 M. M. Crowe</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16 1932

22. I HEREBY CERTIFY, That I attended deceased from 2-15 1932 to 2-16 1932  
 I last saw him alive on 2-16 1932—Death is said to have occurred on the date stated above, at 1:50 a.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis Date of onset       
23  
 Other contributory causes of importance:  
①  
 Name of operation none Date of       
 What test confirmed diagnosis?      Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?      Date of injury     , 19      
 Where did injury occur?       
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury       
 Nature of injury     

24. Was disease or injury in any way related to occupation of deceased?       
 If so, specify       
 (Signed) R. C. Williams M. D.  
 (Address) Supt R. C. Gen Hosp KC Mo

