

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 1309)

Registration District No. 398
Primary Registration District No. 398

19657
File No. _____
Registered No. 2366 Ward _____
St. _____

2. FULL NAME

(a) Residence, No. 6216 Agnes 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 4 - 1927
7. AGE YEARS 6 MONTHS 5 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. school girl
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas
13. NAME Frank P. Miller
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kans
15. MAIDEN NAME Vivian Hendrick
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Mrs. Frank P. Miller
(ADDRESS) 6216 Agnes, Kansas
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Monica DATE 6-8-1933

19. UNDERTAKER Mrs. C. L. Forster
(ADDRESS) 418 Broadway
20. FILED 6-6-33 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-5-33

22. I HEREBY CERTIFY, That I attended deceased from 6-5-33 to 6-5-33, 1933

I last saw her alive on 6-5-33, 1933 Death is said to have occurred on the date stated above, at 9:30 P.M.

The principal cause of death and related causes of importance were as follows:

Agranulocytic angina Date of onset 11:57 A.M.

Other contributory causes of importance:

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) D. M. Chaves, M. D.
(Address) St. Joseph Hosp.

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.

