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

JUL 22 1935

Do not use this space.

19844

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 2487

City Kansas City, Mo. (No. Trinity Lutheran Hospital St. Ward)

2. FULL NAME Mrs. Fannie F. Miller

(a) Residence, No. 2517 Askew St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Geo. B. Miller

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 16, 1876

7. AGE — YEARS: 59 — MONTHS: 0 — DAYS: 0 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Practical Nurse
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): Ill

FATHER

13. NAME: John Foore
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Maine

MOTHER

15. MAIDEN NAME: Ellison Cooper
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Canada

17. INFORMANT (ADDRESS): Mrs. Walter D. Payne, 2517 Askew, K.C.Mo.

18. BURIAL, CREMATION, OR REMOVAL — PLACE: Forest Hill — DATE: June 19-35

19. UNDERTAKER (ADDRESS): C.H.Blackman & Son, Inc. 2825 Indep. Blvd.K.C.Mo.

20. FILED 6-18, 1935 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): June 16, 1935

22. I HEREBY CERTIFY, That I attended deceased from May 18, 1935, to June 16, 1935. I last saw her alive on June 16, 1935. Death is said to have occurred on the date stated above, at 6:30 P.m.

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

	Date of onset
Terminal Bronchopneumonia	6/14/35

Other contributory causes of importance:

Post operative Peritonitis	5/28/35
Non Malignant Cyst	

Name of operation: Removal of Ovarian Cyst — Date of: 5/21/35

What test confirmed diagnosis? Autopsy — 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? No

If so, specify

(Signed) John M. Powers, M. D.

(Address) 3322½ E. 27th