

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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town 1st C.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Home 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Life
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
 (c) City or town 1st C.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 15-15 White
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME William S. Miles 420
 3. (c) Social Security No. ✓
 8. (b) If veteran, name war ✓

20. DATE OF DEATH: Month Dec day 15
 year 1939 hour 3 minute 30 A.M.

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife American Male
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 15- 1853
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 7, 1939, to Dec 15, 1939
 that I last saw him alive on Dec 11, 1939
 and that death occurred on the date and hour stated above.

8. AGE: Years 86 Months 10 Days 0
 If less than one day _____ hr. _____ min.

Immediate cause of death apoplexia
 Due to Senility
 Due to _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 10. Usual occupation Farmer
 11. Industry or business Gen Salesman
 MOTHER FATHER { 12. Name John D. Miller
 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name America
 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Other conditions acute gastritis
 (Include pregnancy within 3 months of death) 1 day

16. (a) Informant's own signature Harley Miller
 (b) Address 6422 E. 15th St
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18-39
 (Month) (Day) (Year)
 (c) Place: burial or cremation Chamwood
 18. (a) Signature of funeral director Dores Henderson
 (b) Address 1416 1/2 W
 19. (a) Dec. 16, 1939 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

Major findings: Of operations None
 Of autopsy none held

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 _____ (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature R. P. Gallagher (M. D. or other) _____
 Address 647 1/2 15th St KC Mo Date signed 12-16-39

5/11 1955
234 6000 011

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed John B. Camp
Licensed Embalmer No. 2955
P. O. Address 19 C. 2nd

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.