

FILED FEB 26 1940

Registration District No. **399**Primary Registration District No. **1002**Registrar's No. **115**

1. PLACE OF DEATH:

(a) County Missouri /
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Mary's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 50 Days
 (Specify whether
 In this community about 45 yrs.
 years, months or days)

3. (a) PRINT
FULL NAMEJohn S. Miller **460**3. (b) If veteran,
name war.Unknown3. (c) Social Security
No. No4. Sex Male5. Color or
race White6. (a) Single, widowed, married,
divorced Married

6. (b) Name of husband or wife

Harriett M. Miller6. (c) Age of husband or wife if
alive 73 years

7. Birth date of deceased

August261865

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

74410

hr.

min.

9. Birthplace

Illinois

(City, town, or county)

(State or foreign country)

10. Usual occupation

Retired R. R. Engineerx

11. Industry or business

MOTHER FATHER

12. Name Robert Miller

13. Birthplace

Pennsylvania

(City, town, or county)

(State or foreign country)

14. Maiden name

Harriett Stanley

15. Birthplace

Indiana

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Paul M. Miller

(b) Address

4935 Shawnee Mission Rd. K.C. Mo.17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof

1-9-40

(Month) (Day) (Year)

(c) Place: burial or cremation

Mt. Moriah Cemetery

18. (a) Signature of funeral director

Stino & McClure

(b) Address

3235 Gillham Plaza, K. C., Mo.19. (a) Jan. 9, 1940
(Date received local registrar)

(b)

M. M. Brown

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4439 Scarritt
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6th
 year 1940 hour 10:50 minute P. M.

21. I hereby certify that I attended the deceased from 5-14-39
 1939, to Jan 6, 1940
 that I last saw him alive on Jan 6, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death

Acute - chronic heart disease
with chronic dilation of heart

Duration

7 mos.

Due to

Due to

Other conditions

(Includes pregnancy within 3 months of death)

Bilateral pleural
effusion

Major findings:

Of operations

Of autopsy

as above, needed

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (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?

While at work

(Specify type of place)

(e) Means of injury

23. Signature J. E. Coe (M. D. or other)
 Address 1002 Argyle Bldg Date signed 1-8-40

J. C. Dr. Castles. 4a 5037
2-11-5
except 7 hours

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 J. B. Peters

Licensed Embalmer No. 3992

P. O. Address K C No.

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.