

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **30918**
 Registrar's No. **3481**

Registration District No. **399**

Primary Registration District No. **1002**

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.

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Trinity Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community **65 Years**
years, months or days
William R. B. Miller

3. (a) PRINT FULL NAME **W.R.B. Miller**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **none**

4. Sex **Male**
 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Hazel B. Miller**
 6. (c) Age of husband or wife if alive **54** years

7. Birth date of deceased **Feb. 27, 1874**
(Month) (Day) (Year)

8. AGE: Years **66** Months **6** Days **5**
 If less than one day _____ hr. _____ min.

9. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Time Keeper**

11. Industry or business _____

MOTHER FATHER { 12. Name **William C. Miller**
 13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
 14. Maiden name **Phoebe Pottenger**
 15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Hazel B. Miller**
 (b) Address **2925 Baltimore Ave.**

17. (a) **Burial** (b) Date thereof **9-5-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **Freeman Mortuary**
 (b) Address **Kansas City Missouri**

19. (a) **Sept. 5, 1940** (b) **M. H. Browne**
(Date received local registrar) (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. **2925 Baltimore Ave.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **11** year **1940** hour **11:30** minute **50** M.

21. I hereby certify that I attended the deceased from **March 19**, 19____, to **Sept 2**, 19____; that I last saw him alive on **Sept 2**, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Abdominal Aorta** Duration **6 mo**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Adenoma Carcinoma**
 Of operations _____
 Of autopsy _____

PHYSICIAN
 Underline the cause to which death should be charged statistically

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? **361**

While at work? _____ (Specify type of place)
 (e) Means of injury **1**

23. Signature **H. S. Hickok** (M. D. or other) _____
 Address **1025 1/2 W. 12th St. Bluff** Date signed _____

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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 *Clarence W. Chiles*

Licensed Embalmer No. *3473*

P. O. Address. *76 E 360*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. Primary Registration District No.

Registrar's No. 2481-

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution: Trinity Hosp.
(d) Length of stay: In hospital or institution. (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME William R. B. Miller

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
..... hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) 9/5/40 (b) M. D. Browe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Feb. day 2-40 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of abdominal viscera sigmoid we think of Germany
Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death) HL
Major findings Of operations: Adenoma Car-
Of autopsy: no post

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

S-30918