No. 2
4-13-40
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I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41369

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4762

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County ~~Jackson~~
(c) City or town Sedalia Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1301 E-9th
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Emma A. Miller
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Fredrick Miller
6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased July (Month) 18 (Day) 1875 (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	4	26	hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation Housewife 6
11. Industry or business
MOTHER FATHER
12. Name William Logan 6
13. Birthplace (City, town, or county) Germany (State or foreign country)
14. Maiden name Pauline Hansen
15. Birthplace (City, town, or county) Germany (State or foreign country)
16. (a) Informant Fredrick Miller
(b) Address Sedalia Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 15-40 (Month) (Day) (Year)
(c) Place: burial or cremation Sedalia Mo
18. (a) Signature of funeral director Mrs C L Fonter
(b) Address 918 Brooklyn
19. (a) 12/15/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14 year 1940 hour 7 minute 55 P.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.

	Duration
Immediate cause of death: Serofibrinous pleurisy (right) extrusion of gastric contents into right thoracic cavity	
Due to: perforation of esophagus	
Due to: (followed dilation of stricture) Cause of stricture not elicitated	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature David J. Stump (M.D. or other) M.D.
Address Research Hospital, Kansas City, Missouri Date signed 12-14-40

(Licensed Embalmer's Statement on Reverse Side)

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. Clair Sheppard

Licensed Embalmer No. 4179

P. O. Address K. C. Mo.

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

If this body is not embalmed, fact should be so stated above.