

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34065

Registration District No. 377

Primary Registration District No. 1002

Registrar's No. 4005

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution 1633 Euclid
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 Yrs (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit - write "RURAL")
(d) Street No. 1633 Euclid Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24th
year 1941 hour 7:00 minute _____ A. M.
21. I hereby certify that I attended the deceased from Oct 23-41
_____ 19____ to Oct 24 1941
that I last saw him alive on Oct 24 19____
and that death occurred on the date and hour stated above.
Immediate cause of death Lobar Pneumonia

Duration

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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 [Signature] (M. D. or other) _____
Address 1705 E 12 Date signed Oct 26-41

8. (a) PRINT FULL NAME Albert Miller

3. (b) If veteran, name war _____ 3. (c) Social Security No. 410

4. Sex Male 5. Color or race NEGRO 6. (a) ~~Single, married, or divorced~~ 3 divorced div

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

7. Birth date of deceased Jan. 10th 1893
(Month) (Day) (Year)

8. AGE: Years 49 Months 9 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Interior Decorator

11. Industry or business Self

12. Name Sanford Miller

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

14. Maiden name Mary Jane Holmes

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

16. (a) Informant Mary Williams

(b) Address 1144 Cambridge St. K. C. Ks

17. (a) Burial (b) Date thereof Oct. 27/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director C. H. Countee

(b) Address 3409 Forest

19. (a) 10/27/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

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

48
308

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.....

working under my personal supervision.

Registered Apprentice No.

Signed *C. H. Combs*.....

Licensed Embalmer No. *1271*.....

P. O. Address *Kansas City Mo*.....

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.