V. S. No. 2
OM—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
REC'D MAR 9 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5509

Registration District No. 3[illegible]

Primary Registration District No. 1002

Registrar's No. 664

1. PLACE OF DEATH:

(a) County Jackson,

(b) City or town KansasCity,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3918 Charlotte, /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution x (Specify whether
In this community 54 years,
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson, 48

(c) City or town Kansas City, 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3918 Charlotte, 8
(If rural, give location)

(e) Citizen of foreign country? x (Yes or No)

If yes, name country x 0

3. (a) PRINT FULL NAME Mrs. Etta 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 Divorced, 3

6. (b) Name of husband or wife W. W. Miller,

6. (c) Age of husband or wife if alive x years

7. Birth date of deceased March (Month) 9 (Day) 1865 (Year)

8. AGE:

Years	Months	Days	If less than one day
76	11	4	hr. min.

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

10. Usual occupation at home,

11. Industry or business x

FATHER
12. Name Gotlieb Henissey,
13. Birthplace Virginia, / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Amanda -
15. Birthplace New York, / (City, town, or county) (State or foreign country)

16. (a) Informant W. A. Miller,
(b) Address 5180 Roseland Lane, K. C., Kansas

17. (a) Burial, (Burial, cremation, or removal) (b) Date thereof 2-16-42 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery,

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 2/16/42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 13th
year 1942 hour 10:15 minute P. M.

21. I hereby certify that I attended the deceased from June 20 1941 19 to Feb 13 1942
that I last saw her alive on Feb 13, 1942 19
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of pylorus

Due to 46 B

Due to

Other conditions Chronic myocarditis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy no

Duration 1 year

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 0

23. Signature M. B. Caselbolt M.D. (M. D. or other)
Address 715 Argyle Bldg K.C. Mo. Date signed 8-14-42

(Licensed Embalmer's Statement on Reverse Side)

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.....

Registrar's No.....

Primary Registration District No.....

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) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... 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.....

Due to.....

Due to.....

Dr. Casebolt 10-30

Other conditions..... (within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

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)

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... (State or foreign country), Registered Apprentice No..... working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 1415

P. O. Address [illegible], 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, fact should be so stated above.

(Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)