

S. No. 2
M-9.4-41
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **3482**

FILED OCT 5 1942/49
Registration District No. _____

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Lakeside Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Days
60 Yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3423 Summit Street
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Mary A. Miller

3. (b) If veteran, name war None

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Clarence L. Miller 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased September 11, 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>0</u>	<u>9</u>	hr. _____ min. _____

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

10. Usual occupation House Wife

MOTHER FATHER

11. Industry or business _____

12. Name John Donegan.

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

14. Maiden name Margaret Fitzmaurice

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

16. (a) Informant Clarence L. Miller.

(b) Address 3423 Summit.

17. (a) Burial (b) Date thereof 9/23/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Melody-McGilley

(b) Address K. C. Mo.

19. (a) 9/22/42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September, day 20th, year 1942, hour 2, minute 32 P.M.

21. I hereby certify that I attended the deceased from Jan 27 1942 to Sept 20 1942 and that I last saw him alive on Sept 20 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Lobar Pneumonia 5 days

Due to Chronic Atherosclerosis Unknown

Due to Chronic Cholecystitis 7 years

Other conditions 127 cc
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Same Chronic Cholecystitis

Of operations _____

Of autopsy None

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 _____

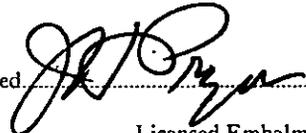
23. Signature George J. Conroy (M. D. or other)

Address 24 E. Tenth St. P.O. 12 Date signed _____

Dr. Carley
Pleasantown Bldg.
116 W 47
Ls 3377

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 .....
Licensed Embalmer No. 2989.....
P. O. Address KC.....

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.