

FILED FEB 10 1943

Registration District No. 199

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas city  
(c) Name of hospital or institution:  
2526 Tracy  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
In this community 4 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 2526 Tracy  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Bertha Miller

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

4. Sex Female 5. Color or race negro 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Olmer Miller 6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased 24 (Month) 1910 (Day) (Year)

8. AGE: Years 32 Months 6 Days 3 If less than one day hr. min.

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

10. Usual occupation House Work

11. Industry or business own home

12. Name Charlie Griffin

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

14. Maiden name Lizzie Howard

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

16. (a) Informant Olmer Miller

(b) Address 2526 Tracy

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-43 (Month) (Day) (Year)

18. (a) Signature of funeral director [Signature] (b) Address 440 State St. R.C. 43

19. (a) 1-30-43 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 27 year 1943 hour 6 P.M. minute..... M.

21. I hereby certify that I attended the deceased from Deputy Coroner 19.....  
that I last saw him alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction  
Acute Peritonitis  
Due to Cancer of transverse colon  
Other conditions.....  
(Includes pregnancy within 3 months of death)

Major findings: Of operations.....  
Of autopsy yes

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)  
23. Signature [Signature] (M. D. or other) Address 1832 7th Date signed 1-29-43

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

MOTHER FATHER

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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 Eugene English  
Licensed Embalmer No. 4105  
P. O. Address 440 State ave.

**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.**