

FILED SEP 28 1943 149

Primary Registration District No. 1002

Registrar's No. 3965

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
5816 St. John  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 Years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME AUGUST F. MILLER

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillie Mabel

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Sept. 18, 1864  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	11	25	hr. _____ min.

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

10. Usual occupation Cleaning Shop Presser

11. Industry or business Self

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Lillie Mabel Miller

(b) Address 5816 St. John

17. (a) Burial  
(Burial, cremation, or removal)

(b) Date thereof Sept. 15,  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director C. H. Blackman & Son

(b) Address Kansas City, Mo.

19. (a) 9-15-43  
(Date received local registrar)

(b) J. E. Brown  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 5816 St. John  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13  
year 1943 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from Mar. 1941 to Sept. 12, 1943  
that I last saw him alive on Sept. 11, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia 3 days

Due to Decompensated myocarditis 10 yrs.

Due to Essential hypertension & arteriosclerosis 15 yrs.

Other conditions 73d.  
(Includes pregnancy within 3 months of death)

Major findings: 73d.

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? \_\_\_\_\_

23. Signature J. J. Goscik (M. D. or other) 2 DO

Address 5402 St. John Date signed 9/13/43

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

MAY 17 1944

**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.....

P. O. Address.....

**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.**

MAY 17 1944

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