

FILED NOV 19 1943

Registration District No. **149**

Primary Registration District No. **1002**

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: Trinity Lutheran Hospital, 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 5 weeks (Specify whether  
In this community all her life, (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**  
(c) City or town Kansas **3**  
(If outside city or town limits, write "RURAL") **8**  
(d) Street No. 3019 Askew,  
(If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No)  
If yes, name country X **0**

3. (a) PRINT FULL NAME Miss Annamaye Miller,

3. (b) If veteran, name war no.  
3. (c) Social Security No. 481-09-0018

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

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

7. Birth date of deceased February 20 1917  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
26 8 4 hr. min.

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

10. Usual occupation none Stenographer

11. Industry or business X

12. Name William H. Miller,

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

14. Maiden name Ethel G. Wells,  
(City, town, or county) (State or foreign country)

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

16. (a) Informant William H. Miller,  
(b) Address 3019 Askew, Kansas City, Mo.

17. (a) Burial (b) Date thereof 10-26-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

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

19. (a) 10-26-43 (b) Def. J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

DATE OF DEATH: Month October day 24th  
year 1943 hour 5:50 minute 15 a. m.

I hereby certify that I attended the deceased from Oct 31  
1942 to Oct 24 1943.

that I last saw her alive on October 23 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death -  
Mitral stenosis 2 yrs  
congestive heart failure 2 mos  
Due to - Rheumatic mitral  
valvulitis 6 yrs.

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 92%

Major findings: \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Graham Asher (M. D. or other) MD

Address 1220 Prof. Bldg. Date signed 10-25-43

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

MOTHER: FATHER:

7  
Dr. Arthur  
Cristof Bledy

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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..... *E. M. Plouffe* .....

Licensed Embalmer No. *1848* .....

P. O. Address *R. C. 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.