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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. **5059**

FILED DEC 22 1943

Registration District No. **149** 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  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 1 week  
(Specify whether)

In this community 1 2 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson <sup>48</sup>

(c) City or town K.C.  
(If outside city or town limits, write "RURAL")

(d) Street No. 3826 W. Yandotte  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Anna Miller

3. (b) If veteran, name war no.

3. (c) Social Security No. 495-06-2506

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 29 1943  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 3A A.M.

21. I hereby certify that I attended the deceased from June 1940  
19 \_\_\_\_\_ to Nov 29 1943  
that I last saw her alive on Nov 29 1943  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Charles Miller

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Aug 3 1912  
(Month) (Day) (Year)

Immediate cause of death: peritonitis pelvic inflammation

Due to: operation

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration: 1 week

8. AGE: Years Months Days If less than one day

31 | 3 | 26 | \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Defense Worker - Lake City

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Frank Forge

{ 13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

Major findings: infected tubes

Of operations: chronic

Of autops: peritonitis

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Charles Miller

(b) Address 3826 W. Yandotte

17. (a) Burial, cremation, or removal St. Marys Cem

(b) Date thereof 12-1-43  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cem

18. (a) Signature of funeral director W. E. Brown

(b) Address 16110

19. (c) 12-1-43 (b) W. E. Brown  
(Date received local registrar) (Registrar's signature)

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 M. B. Caspell (Registrar or other)

Address 4000 Baltimore K.C. Date Nov 1-43

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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..... *Harold Doe* .....

Licensed Embalmer No..... *2810* .....

P. O. Address..... *N. 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.**