

No. 2
9-4-41
5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41170
State File No. _____
Registar's No. **5163**

FILED DEC 22 1943 / 149
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**
(c) Name of hospital or institution: **K.C. TB Hospital**
(d) Length of stay: In hospital or institution **3 yrs 3 m 13 d**
In this community **29 yrs**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **1741 1/2 Lydia**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Obie Miller**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **M** 5. Color or Race **C** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Beattie Miller** 6. (c) Age of husband or wife if alive **unk** years
7. Birth date of deceased **11 22 1883**

8. AGE: Years **59** Months **11** Days **21** If less than one day hr. min.

9. Birthplace **Arkansas**

10. Usual occupation **Porter**

11. Industry or business _____

MOTHER FATHER } 12. Name **Joe Miller**

13. Birthplace **Arkansas**

14. Maiden name **Vellie Beaton**

15. Birthplace **Arkansas**

16. (a) Informant **Records K.C. TB Hosp.**

(b) Address **Leeds Mo**

17. (a) **Burial** (b) Date thereof **12-8-43**

(c) Place: burial or cremation **Leeds Mo**

18. (a) Signature of funeral director **Tom R. Brown**

(b) Address **City, Mo**

19. (a) **12-7-43** (b) **P. E. Brown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **13** year **43** hour **7:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **7-31-40** to **11-13** 19**43**

that I last saw h. i. m. alive on **11-13** 19**43** and that death occurred on the date and hour stated above.
Immediate cause of death **Acute Dilatation of Heart**
Pulmonary Tuberculosis
Hypertension

Due to _____
Due to **12/11**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy **same**

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 **0**

23. Signature **Matthew J. Brown** (M. D.) _____
Address **Leeds Mo** Date signed **11/13/43**

Sudden Duration
3 1/2 yrs
3 1/2 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.