

THE STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

110001  
 State File No.  
 1065  
 Registrar's No.

Registration District No. 149

Primary Registration District No. 10072

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:  
3954 Wyandott St.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 35 Years  
years, months or days)

3. (a) PRINT FULL NAME Charles Edward 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 E. Jennie Miller  
 6. (c) Age of husband or wife if alive unfr years  
 7. Birth date of deceased September 8 1858  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
85 5 27 hr. min.

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

10. Usual occupation Retired Salesman

11. Industry or business  
 12. Name John F. Miller  
 13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
 14. Maiden name Sarrah Fritch  
 15. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. E. Jennie Miller  
 (b) Address 3954 Wyandott, St.

17. (a) Burial  
(Burial, cremation, or removal) (b) Date thereof 3-8-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Freeman Mortuary  
 (b) Address Kansas City, Missouri

19. (a) 3-7-44 (b) T. E. Brown (13)  
(Date received local registrar) (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. 3954 Wyandott  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month March 5 day, 1944  
 year. hour 3:15 min. AM  
 21. I hereby certify that I attended the deceased from June 1943 to March 5 1944  
 that I last saw him live on March 5 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
 Due to Arteriosclerosis 5 yrs  
 Due to Myocarditis 5 yrs  
 Other conditions none  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy no  
 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. D. Casbalt (M. D. or other)  
 Address 4000 Ballwin K. Mo Date signed 3/6/44

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

MOTHER FATHER

**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 *Walter H. Erwin*

Licensed Embalmer No. *4352*

P. O. Address *Kansas City, 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.**

11:40 12:AM