

FILED DEC 4 1944

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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:
1321 Agnes
(If not in hospital or institution, write street number or location)

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

In this community 27 years

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. 1321 Agnes
(If rural, give location)

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

3. (a) PRINT FULL NAME Bessie F. Miller

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

3. (c) Social Security No. No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17
year 1944 hour 3 minute 50 M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife John T. Miller

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased July 13 1891
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 25 1944 to Nov 17 1944
that I last saw him alive on Nov 17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Wilabety melitris

Duration _____

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>3</u>	<u>29</u>	hr. _____ min. _____

Due to _____

Due to _____

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

10. Usual occupation At Home

11. Industry or business _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Riley Martin

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

14. Maiden name Amy

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

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? _____

16. (a) Informant John T. Miller

(b) Address 1321 Agnes

17. (a) Burial (b) Date thereof 11-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C. L. Foster

(b) Address 1321 Agnes K.C. Mo

19. (a) 11-20-44 (b) H. E. Brown
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury 3

23. Signature H. M. Wheeler (M. D. or other) _____

Address 557 Minnesota Ave Date signed Nov 18

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

Dr. W. S. Sueder
Dr. 1897
552 Minnesota

Pay at Home 9:30

2-5-97

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 C. H. Wise

Licensed Embalmer No. 2570

P. O. Address 100 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.