

S. No. 2
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 rev. 5-17-36
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED FEB 6 1945
 Registration District No. 179

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. 368

Primary Registration District No. 1602

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: Research Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days)
 In this community 38 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. 6336 Walnut Street
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Helen Maude Miller
 3. (b) If veteran, name war no 3. (c) Social Security No. none
 4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Stephen H. Miller 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased August 23rd 1882
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 22nd
 year 1945 hour 1:30 minute A. M.
 21. I hereby certify that I attended the deceased from Jan 6 1945 to Jan 22 1945
 that I last saw him alive on Jan 21 1945
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>4</u>	<u>29</u>	hr. _____ min. _____

Immediate cause of death: Cerebral Hemorrhage
 Due to: Arterial Hypertension
 Due to: Arteriosclerosis
 Other conditions: _____
(Include pregnancy within 3 months of death)
 Major findings: 830
 Of operations: _____
 Of autopsy: _____

9. Birthplace Wellsville, Kansas
(City, town, or county) (State or foreign country)
 10. Usual occupation At home

11. Industry or business
 12. Name Dr. Howard M. Bennett
 13. Birthplace Penn.
(City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Noss
 15. Birthplace Penn.
(City, town, or county) (State or foreign country)

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

16. (a) Informant Stephen H. Miller
 (b) Address 6336 Walnut Street

17. (a) Burial (b) Date thereof 1-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Forest Hill Cemetery
 18. (a) Signature of funeral director Freeman Mortuary
 (b) Address Kansas City, Mo.
 19. (a) 1-23-45 (b) H. 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 W. R. Ferris (M. D. or other)
 Address 434 Argyle Bldg Date Jan 22 1945
Kansas City, Mo

Mr. [unclear]
2-5

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.....

Joseph R. Hunt Registered Apprentice No. *364*
working under my personal supervision.

Signed *George E. Fessman*

Licensed Embalmer No. *481*

P. O. Address *K. 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.