

FILED MAR 7 1945
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 813

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:
Memorah Hosp D
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. 13 da
(Specify whether years, months or days) 15 yrs

In this community 15 yrs

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. 309 W. 13th St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Vesta Miles Fine

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe | 5. Color or race Wh

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

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Oct 31 1895
(Month) (Day) (Year)

8. AGE: Years 49 Months 3 Days 18 1/2 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Thomas Miles

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

14. Maiden name Laura Chapel

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

16. (a) Informant Mrs Edith O'Shea

(b) Address St Joseph Missouri

17. (a) Removal (b) Date thereof 2-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Mo.

18. (a) Signature of funeral director Louis Funeral Home

(b) Address K.C. Mo.

19. (a) 2-19-45 (b) M. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 18th
year 1945 hour 12 minute 45 P. M.

21. I hereby certify that I attended the deceased from Jan 15
1945 to Feb 18th 1945

that I last saw he alive on Feb 18th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid hemorrhage 6 weeks

Due to aneurysm or vasculitis of cerebral vessels

Due to _____

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

Major findings: Of operations 96

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

(Specify type of place)

While at work? _____ (e) Means of injury 0

23. Signature M. Joseph Eitelson (M. D. or other)

Address 1219 Ricketts Bldg Date signed 2-19-45

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

MAY 4 1945

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. 3110

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.