. S. No. 2
0M—5-43
ev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26531

State File No.

FILED AUG 22 1945

Registration District No. 999 Primary Registration District No. 1002 Registrar's No. 3301

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: 127 East 46 th, St. K.C. Mo. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None (Specify whether years, months or days)
In this community 33 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 127 East 46 tth, Street 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME ELIZABETH H. MILLER
3. (b) If veteran, name war No
3. (c) Social Security No. 486-26-5243
4. Sex Female /
5. Color or race White
6. (a) Single, widowed, married, divorced Married /
6. (b) Name of husband or wife Joseph L. Miller
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased March (Month) 20 th, (Day) 1896 (Year)

8. AGE: Years 49 Months 4 Days 14 If less than one day hr. min.

9. Birthplace Stewartsville (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Secretary
11. Industry or business U.S. Dept. of Agriculture

FATHER
12. Name Benjamin Hammer
13. Birthplace Platt County (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Nannie Rowell
15. Birthplace Smithville (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Joeseph L. Miller
(b) Address 127 East 46 th, St. K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/45 (Month) (Day) (Year)
(c) Place: burial or cremation Platt City, Mo.
18. (a) Signature of funeral director Mellody-McGilley-Eylar
(b) Address 1800 Linwood Blvd. K.C. Mo.
19. (a) 8-6-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 4th year 1945 hour 7 minute 10 P.M.
21. I hereby certify that I attended the deceased from CORONER, 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary sclerosis	
Due to: Cirrhosis sclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Stomach contents removed for analysis	
Major findings: Of operations:	
Of autopsy: yes - as above	

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

22. If death was due to external causes, fill in the following: Found
(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
23. Signature Jasmine Walter (M. D. or other person)
Address 1424 Grand Ave Date signed 8-5-45

(Licensed Embalmer's Statement on Reverse Side)

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

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 Chas E Wells

Licensed Embalmer No 2644

P. O. Address Hanson Ky

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.

. S. No. 2B
M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3301

SUPPLEMENTARY

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: 127 E. 46th. St. (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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Elizabeth H. Miller

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 8-6-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 4 year 1945 hour 7 minute 100 M.

21. I hereby certify that I attended the deceased from Coroner to, 19; that I last saw h. alive on, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary sclerosis	
Due to arteriosclerosis	
Due to 94a	
Other conditions (Include pregnancy within 3 months of death) stomach contents removed for analysis (no poison)	
Major findings: Of operations	
Of autopsy yes, as above	

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

23. Signature James C. Walker (M. D. ~~or other~~)

Address 1424 W. 39th Date signed 8-5-45

26531