

S. No. 2  
M-5-43  
v. 5-17-39  
I X3667

FILED OCT 29 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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:  
4210 Walnut /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 15 years  
years, months or days

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. 4210 Walnut 7  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MAURICE MILLER

3. (b) If veteran, name war World War 11

3. (c) Social Security No. 486-01-4390

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12th day Oct  
year 1945 hour 5:20 minute 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.

4. Sex Male ( ) 5. Color or race White

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

6. (b) Name of husband or wife Ruth Miller

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

7. Birth date of deceased Jan 21 1906  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Arterial sclerosis

Due to arterial sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 94a  
Of operations \_\_\_\_\_

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

39 8 21 hr. min.

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

10. Usual occupation Office Manager

11. Industry or business Metro Premium Co

MOTHER FATHER {

12. Name Samuel Miller

13. Birthplace Russia 6  
(City, town, or county) (State or foreign country)

14. Maiden name Anna White

15. Birthplace Russia 6  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Beth Chenevert

(b) Address  Tulsa Oklahoma

17. (a) Burial (b) Date thereof 10/15/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Frank E. Rubin

(b) Address 20 West Linwood

19. (a) 10-15-45 (b) Steraldine Holmes  
(Date received local registrar) (Registrar's signature)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Of autopsy no  
Histology & Prospecimen

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 fall

23. Signature Samuel Miller (M. D. or other) Steraldine  
Address 1424 1/2 W 21st Date signed 10-14-45

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 Charles M. Quirk

Licensed Embalmer No. 3774

P. O. Address 204 Linwood R.O.M.

**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.**