

No. 2
M-5-43
5-17-39
I X36671

FILED NOV 26 1945

State File No.

4616

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:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 Days**
(Specify whether)

In this community **6 Years**
(years, months or days)

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. **4014 Warwick Blvd.**
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME **MRS. MILDRED E. MILLER**

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

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **6th**
year **1945** hour **11 30** minute **0** M.

4. Sex **Female** / 5. Color or race **White**

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

6. (b) Name of husband or wife **Claude F. Miller**

6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **October 19, 1894**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Perone**, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years **51** Months **0** Days **18 17**
If less than one day _____ hr. _____ min.

Immediate cause of death **Multiple petechial hemorrhage of brain**

Due to **Chronic Hemorrhagic Septicemia**

Due to **puering**

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **yes - as above**

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

10. Usual occupation **At Home**

11. Industry or business

MOTHER FATHER

12. Name **Andrew Mc Conighen**

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

14. Maiden name **Hannah Northcote**

15. Birthplace **Milwaukee** **Wisconsin**
(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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Geraldine Holmes** (M., D. or other)

Address **1424 Bay Ave** Date signed **11-7-45**

16. (a) Informant **Claude F. Milber**

(b) Address **4014 Warwick Blvd.**

17. (a) (Burial, cremation, or removal) **Removal** (b) Date thereof **11-8-45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Milwaukee, Wisconsin**

18. (a) Signature of funeral director **Freeman Mortuary**
Kansas City, Missouri

(b) Address

19. (a) **11-8-45** (Date received local registrar) (b) **Geraldine Holmes** (Registrar's signature)

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..... *Walter F. Erwin*

Licensed Embalmer No..... *4352*

P.O. Address..... *Kansas City, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4616

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
(years, months or days)

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

3. (a) PRINT FULL NAME Mildred E. 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 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-8-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 13 Year 1945 Hour 3:00 Minute 00 M.

21. I hereby certify that I attended the deceased from _____ 19____; that I first saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Multiple petechial hemorrhage of brain

Due to _____
Due to Chronic glomerular nephritis

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

Major findings: 8301
Of operations _____

Of autopsy yes, as above

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 James C. Walker (M. D. or other) _____

Address 11424 Prof. Bldg Date signed 11-7-45

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

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

36308