

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13281**
Registrar's No. **1957**

FILED MAY 6 1946
Registration District No. **149**

Primary Registration District No. **1002**

18
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town KC Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Mary's Hosp. 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 hrs 47 min
 (Specify whether In this community 4 hrs 17 min years, months or days)

3. (a) PRINT FULL NAME Baby Boy Miller
3. (b) If veteran, name war - no **3. (c) Social Security** No. none

4. Sex male **5. Color or race** W **6. (a) Single, widowed, married, divorced** single
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____ **alive** _____ years
7. Birth date of deceased 4-26-46
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 4 hr 47 min

9. Birthplace KC Mo 0
 (City, town, or county) (State or foreign country)

10. Usual occupation N.B.

11. Industry or business N.B.

12. Name Albert Benjamin Miller
13. Birthplace Rosedale, Kans
 (City, town, or county) (State or foreign country)

14. Maiden name Agnes Elvora Crowley
15. Birthplace Rosedale, Kans
 (City, town, or county) (State or foreign country)

16. (a) Informant mother
(b) Address 200 Elm Shawnee Kans

17. (a) Burial, cremation, or removal Reburial **(b) Date thereof** 4-27-46
 (Month) (Day) (Year)
(c) Place: burial or cremation Shannon Cem.

18. (a) Signature of funeral director Bill Daniels
(b) Address 655 Howard Ave. K.C. Mo

19. (a) 4-27-46 **(b)** Gerardine Holmes
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Kans (b) County Johson
 (c) City or town Shawnee 14
 (If outside city or town limits, write "RURAL")
 (d) Street No. 200 Elm 3
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No) 2
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4- day 26
 year 1946 hour 5: minute 02 P.M.
21. I hereby certify that I attended the deceased from 4-26- 1946, to 4-26 1946
 that I last saw him alive on 4-26 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death atelectasis **Duration** _____
 Due to Prematurity
 Due to _____

Other conditions 159
 (Include pregnancy within 3 months of death)

Major findings: _____ **PHYSICIAN** _____
 Of operations _____
 Of autopsy atelectasis, Prematurity
 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?
 While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Bill Daniels (M. D. or other) N.D.
Address 1401 Southwest Blvd. **Date signed** 4/27/46

12107

14015. W. Blvd.

Dr. Rehabilitation.

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..... Augustine C. Warner.....

Licensed Embalmer No. 2597.....

P. O. Address. 1734 Washington Blvd. KSK.

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.