

THE STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **4979**
 Registrar's No. **518**

Registration District No. **149** 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: **GENERAL HOSPITAL NO. 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 DAYS**
 (Specify whether years, months or days) **Not Known**

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. **1710 CHARLOTTE**
 (If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME. **FRED MILLER**
 3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**
 4. Sex **MALE** 2 5. Color or race **NEGRO** 9
 6. (a) Single, widowed, married, divorced **unknown**
 6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **unknown**
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **JANUARY** day **24**, year **1947** hour **4:** minute **00 A.** M.
21. I hereby certify that I attended the deceased from **JANUARY 16, 1947** to **JANUARY 24, 1947** and that death occurred on the date and hour stated above.
 that I last saw h. **IM** alive on **JANUARY 24, 1947**

Immediate cause of death **CEREBRAL VASCULAR ACCIDENT**
 Due to **HYPERTENSIVE HEART DISEASE**
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

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) (c) Means of injury **0**
23. Signature. **V. E. G. G. G.** (M. D. or other) **M. D.**
 Address **GENERAL HOSPITAL NO. 2** Date signed **1/24/47**

8. AGE: Years Months Days If less than one day
apparently 65 hr. min.
9: Birthplace **Not Known** 9 (City, town, or county) (State or foreign country)
10. Usual occupation. **Not Known**
11. Industry or business. _____
12. Name. **Not Known** 9
13. Birthplace. **Not Known** 1 (City, town, or county) (State or foreign country)
14. Maiden name. " " 9
15. Birthplace. **Not Known** 9 (City, town, or county) (State or foreign country)
16. (a) Informant. **Reed Clark Gurdick**
(b) Address. **K.C., Mo.**
17. (a) **Reed Clark Gurdick** **(b) Date thereof** **2-6-47**
 (Resident, transient, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation. **University of K.C.**
18. (e) Signature of funeral director. **N.B. Moore**
(b) Address. **1820 E. 15th**
19. (a) **2-4-47** **(b) A. Waldine Holmes**
 (Date received from registrar) (Registrar's signature)

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

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 *HB Moore*.....

Licensed Embalmer No. *2410*.....

P. O. Address. *1820 E 18 st*.....

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.