

FILED AUG 13 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3242

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. 1  
(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)  
In this community 25 YEARS

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. 3404 MICHIGAN AVENUE  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

EDITH Grace Miles

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife EDWIN D. MILES

6. (c) Age of husband or wife if alive 18 1/2 years

7. Birth date of deceased JANUARY 1 1867  
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 29  
If less than one day hr. min.

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

10. Usual occupation AT HOME

11. Industry or business

12. Name ALEXANDER SCHLEGEL

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

14. Maiden name UNKNOWN

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

16. (a) Informant MR. EDWIN HAROLD MILES

(b) Address 3404 MICHIGAN AVENUE

17. (a) BURIAL (b) Date thereof AUG 2 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MARIAN CEMETERY

18. (a) Signature of funeral director D. H. Newcomer Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 8-1-47 (b) Geraldine Holme  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30  
year 1947 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 22, 1947, to July 30, 1947;  
that I last saw her alive on July 30, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 830

Of autopsy None

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 Tom W. Hart (M.D. or other)

Address Med. Dir. Gen'l Hosp. Date signed 7-31-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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**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 *Jesse T. Deew*.....

Licensed Embalmer No. *4453*.....

P. O. Address *St. Louis City*.....

**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.**