

U.S. National Office of Vital Statistics  
**FILED** AUG 7 1947  
Registration District No. ....

Primary Registration District No. **1002**

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

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: **Commodore Hotel, 1217 Linwood Blvd.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **none**  
(Specify whether)

In this community **Unknown**  
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. **1217 Linwood Blvd.** **8**  
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME **Paul O. MILLER**

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

3. (c) Social Security No. **495-03-0680**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **21**  
year **1947** hour **11** minute **45** P. M.

4. Sex **male**

5. Color or race **white**

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

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

6. (c) Age of husband or wife if alive **15** years

7. Birth date of deceased **October 15, 1888**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **before** 19..... to..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Duration

8. AGE:	Years	Months	Days	If less than one day
	<b>58</b>	<b>9</b>	<b>6</b>	..... hr. .... min.

Immediate cause of death **Cerebral sclerosis**

Due to **Cerebral sclerosis**

9. Birthplace **Montreaux, Switzerland**  
(City, town, or county) (State or foreign country)

Due to .....

Other conditions (include pregnancy within 3 months of death) **93d**

10. Usual occupation **Employee**

PHYSICIAN

Underline the cause of which death should be charged statistically.

Major findings: Of operations .....

Of autopsy **no**

11. Industry or business **Anchor Roofing Company**

12. Name **Unknown**

13. Birthplace **Unknown Unknown 9**  
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown Unknown 9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **General Hosp. Records**

(b) Address **K.C. Mo.**

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? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

(Specify type of place)

While at work? .....

(e) Means of injury .....

17. (a) **Burial** (b) Date thereof **7-25-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Int. Jewish**

18. (a) Signature of funeral director **Melody McGilley-Eylan**

(b) Address **Kansas City, Mo.**

19. (a) **7-23-47** (b) **Heraldine Holmes**  
(Date received local registrar) (Registrar's signature)

23. Signature **Paul O. Miller** (M. D. or other) **47**

Address **1424 1/2 St. W.** Date signed **7-27-47**

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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

*Elen E. Heck*

Licensed Embalmer No. \_\_\_\_\_

4063

P. O. Address \_\_\_\_\_

*R E Mrs.*

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.