

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED JUN 19 1948  
Registration District No. 149

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2074

Primary Registration District No. 1002

WRITE PLAINLY—USE 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: GENERAL HOSPITAL NO. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 DAY  
(Specify whether years, months or days) 1 day

3. (a) PRINT FULL NAME

INFANT MILLER

3. (b) If veteran, name war

No

3. (c) Social Security No.

None

4. Sex MALE 2

5. Color or race NEGRO

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased MARCH (Month)

26, 1948 (Day) (Year)

8. AGE:

Years Months Days If less than one day  
1 hr. min.

9. Birthplace KANSAS CITY (City, town, or county)

MISSOURI (State or foreign country)

10. Usual occupation NONE

11. Industry or business

12. Name K. D. MILLER

13. Birthplace Magnolia (City, town, or county)

Arkansas (State or foreign country)

14. Maiden name PEARLENE STEWART

15. Birthplace STAMPS (City, town, or county)

ARKANSAS (State or foreign country)

16. (a) Informant PEARLENE MILLER (MOTHER)

(b) Address 1515 EUCLID

17. (a) Burial, cremation, or removal (b) Date thereof 6-11-48 (Month) (Day) (Year)

(c) Place: burial or cremation Burial

18. (a) Signature of Interim Director

(b) Address

19. (a) 6-12-1948 (Date received local registrar)

(b) (Registrar's signature)

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. 1515 EUCLID (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 27, year 1948 hour 6: minute 00 P. A. M.

21. I hereby certify that I attended the deceased from MARCH 26, 1948, to MARCH 27, 1948

that I last saw him alive on MARCH 27, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death PREMATURETY (ABOUT 6 MONTHS) Duration  
NEONATAL DEATH

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
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 \_\_\_\_\_ (Specify type of place) (e) Cause of injury \_\_\_\_\_

23. Signature (M. D. or other) Date signed \_\_\_\_\_  
Address 600 East 22nd St.

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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.....

*Not Embalmed*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Wm. A. Lawrence*

Licensed Embalmer No.....

*3089*

P. O. Address.....

*DC MD*

**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.**