No. 300
10.48

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

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16030

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1850

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
c. LENGTH OF STAY (In this place) 46 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1412 W. 39th STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Jackson
c. CITY (If outside corporate limits, write RURAL and give township) Kansas City
d. STREET ADDRESS (If rural, give location) 1412 W 39th Street

3. NAME OF DECEASED (Type or Print) a. (First) Lelia b. (Middle) D. c. (Last) Miller
4. DATE OF DEATH (Month) (Day) (Year) April 25 1949
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH June 15 1856
9. AGE (In years last birthday) 92 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Germanstown, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Sol Miller
13b. MOTHER'S MAIDEN NAME Mary Kaucher
14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. K. Miller Kansas City, Mo. 1412 W 39th

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) 4222

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Senility

INTERVAL BETWEEN ONSET AND DEATH: April 12 to Apr. 25

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr 25, 1949, *to* Apr 25, 1949, *that I last saw the deceased alive on* Apr. 25, 1949, *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE Elsie A. Erickson (Degree or title) Elsie A Erickson D.O.
23b. ADDRESS 4610 Troost Ave
23c. DATE SIGNED Apr 26, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE APR. 28 1949
24c. NAME OF CEMETERY OR CREMATORY —
24d. LOCATION (City, town, or county) (State) TROY KANSAS

DATE REC'D BY LOCAL REG. 4-27-49
REGISTRAR'S SIGNATURE Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE D.W. Newcomer Sons ADDRESS 1331 Brush Creek Kans. City Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Robert Ray

Licensed Embalmer No. 4182

P. O. Address Kansas City, Mo.

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.