

FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30453
3647

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>1</u> <u>9445.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		d. STREET ADDRESS (If rural, give location) <u>1133 E. 17TH ST.</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Kansas City Tuberculosis Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1133 E. 17TH ST.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>FRANKLIN</u> c. (Last) <u>MILLER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>August 14 1949</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 27-1902</u>			
9. AGE (In years last birthday) <u>47</u>		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) <u>Porter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cafe</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Miller, Samuel Lindsay</u>			13b. MOTHER'S MAIDEN NAME <u>Phyor, Martha P.</u>			14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>			16. SOCIAL SECURITY NO. <u>496-16-1264</u>		17. INFORMANT'S SIGNATURE OR NAME <u>H. C. T. B. Hospital</u>		ADDRESS <u>H. C. Mo.</u>		
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION <u>002X</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12-10</u> , 19 <u>45</u> , to <u>8-14</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-14</u> , 19 <u>49</u> , and that death occurred at <u>2:30</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>G.K. Landis, M.D.</u>				23b. ADDRESS <u>K. C. T. B. Hosp.</u>		23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-23-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Kansas University</u>		24d. LOCATION (City, town, or county) (State) <u>LAWRENCE, Kansas</u>			
DATE REC'D BY LOCAL REG. <u>8-24-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. Rody - Braun</u> ADDRESS <u>Kansas City, Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Lawrence A. Jones

Licensed Embalmer No. 4429

P. O. Address 2500 Park Ave
K. C. O. 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.