

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38824
4960

State File No. _____
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	
c. LENGTH OF STAY (In this place) <u>5 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>1654 Madison Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1654 Madison St.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Josie</u> b. (Middle) <u>Miller</u> c. (Last) <u>Miller</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-12-52</u>		
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5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>8-11-1866</u>		9. AGE (In years last birthday) <u>86</u>		10. UNDER 1 YEAR: Months _____ Days _____		10. UNDER 24 HRS. Hours _____ Mins. _____	
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10a. USUAL OCCUPATION (Give kind of work done for the most of working life, or as if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) <u>Coffeyville, Kan.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
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13a. FATHER'S NAME <u>"Unc." West</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>James Miller</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT'S SIGNATURE OR NAME <u>James Weaver</u> ADDRESS <u>Same</u>		
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Arteriosclerotic heart disease</u>		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH									
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		ANTECEDENT CAUSES									
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.									
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.									

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Natural</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:10 a.m., from the causes and on the date stated above.

23. SIGNATURE <u>Hugh H. Owens</u> (Degree or title) <u>3</u>			23b. ADDRESS <u>1034 Beulah Bldg.</u>			23c. DATE SIGNED <u>11-13-52</u>		
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24a. DATE OF CREMATION <u>11-14-52</u>		24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY <u>Waverly</u>		24d. LOCATION (City, town, or county) (State) <u>Waverly Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>11-13-52</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. C. Weiler</u> ADDRESS <u>C. S. No.</u>	
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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

B. E. Wheel

Licensed Embalmer No. _____

4025

P. O. Address _____

C. S. 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.