

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38825

State File No.

FILED NOV 22 1952

4914

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) 20 yrs.		d. STREET ADDRESS (If rural, give location) 4059 Central	
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hospital			

3600

3. NAME OF DECEASED (Type or Print) NORMA MILLER			4. DATE OF DEATH (Month) (Day) (Year) 11 7 1952		
a. (First)	b. (Middle)		c. (Last)		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH 8/2/1897		9. AGE (In years last birthday) Months Days 55 Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME William A. Burns		13b. MOTHER'S MAIDEN NAME Mary E. Jones		14. NAME OF HUSBAND OR WIFE Oscar Miller	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 496-26-5855		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. B. I. Burns, 5421 Wyandotte	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 36 hours
		ANTECEDENT CAUSES 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.			3317

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE David M. Gibson MD (Degree or title) <i>David M. Gibson M.D. (Pathologist)</i>		23b. ADDRESS St. Luke's Hospital K.C. Mo.		23c. DATE SIGNED 11-8-52	
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24a. BURIAL CREMATION, REMOVAL (Specify) Burial 4		24b. DATE 11/10/52		24c. NAME OF CEMETERY OR CREMATORY Woodlawn	
				24d. LOCATION (City, town, or county) (State) Independence, Mo.	

DATE REC'D BY LOCAL REG. 11-10-52		REGISTRAR'S SIGNATURE <i>Seraldine Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FREEMAN MORTUARY & CHAPEL, K.C., MO.	
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Clayton R Barnes

Signed.....

Student Embalmer

Licensed Embalmer No. 4793

P. O. Address F. C. 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.