

FILED OCT 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34043
State File No. 4748

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 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 town(ship)) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. LENGTH OF STAY (to this place) <u>20 yrs</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LAKESIDE HOSP.</u>		STREET ADDRESS (If rural, give location) <u>221 5515 E 16th TERR. 2270</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>LORA</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>MILLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 11 1954</u>	
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 22-1881</u>
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Marshall MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Charles House</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Belle Charles</u>	
14. NAME OF HUSBAND OR WIFE <u>George E Miller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS: <u>George E Miller 5515 E 16th Terr</u>	
18. NO 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) <u>Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Adenocarcinoma of Rectum.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Embolism of Rt Popliteal Artery</u> <u>154X</u>	
19a. DATE OF OPERATION <u>OCT 4 54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Extensive Metastasis in Ovaries, Bladder, & Descending Colon</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>_____ MO. _____</u>	
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?			
22. I hereby certify that I attended the deceased from <u>SEPT 17</u> , 19 <u>54</u> , to <u>OCT. 11</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>OCT 11</u> , 19 <u>54</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>M. M. Grogan</u>		23b. ADDRESS <u>NO. 2 5811 Truman Ave K.C.</u>	
23c. DATE SIGNED		24a. BURIAL, CREMATION-REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>OCT 19, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>INT. OLIVE T</u>	
24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>		DATE REC'D BY LOCAL REG. <u>10-12-54</u>	
REGISTRAR'S SIGNATURE <u>Neva Minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sheil FUNERAL Home K.C. MO.</u>	

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

195. - - - 11/12

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.....
Signature of Student Embalmer

Signed *Thomas A. Sheil*

Licensed Embalmer No. *495*

P. O. Address *D.C. M.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.