

FILED JUL 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22275

2794

BIRTH NO. 44481-55 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2794

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before institution). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town or township) Kansas City	c. LENGTH OF STAY (in this place) Life	c. CITY OR TOWN Kansas City	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 Research Hospital		STREET ADDRESS (If rural, give location) 233 East 46th Street	

3. NAME OF DECEASED (Type or Print) a. (First) CINDY	b. (Middle) JEAN	c. (Last) MILLER	4. DATE OF DEATH (Month) (Day) (Year) 6 30 55
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5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH 6-28-1955	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months 2 Days	IF UNDER 1 HRS. Hours 2 Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX	10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John J. Miller	13b. MOTHER'S MAIDEN NAME Alma J. Preston	14. NAME OF HUSBAND OR WIFE XX
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX	16. SOCIAL SECURITY NO. XX	17. INFORMANT'S SIGNATURE OR NAME John J. Miller, 233 East 46, K.C. Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 days
	ANTECEDENT CAUSES Morbidity 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 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 6/28 1955, to 6/30, 1955, that I last saw the deceased alive on 6/30, 1955, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE Joseph C. Williams (Degree or title) M.D.	23b. ADDRESS 425 E 63rd	23c. DATE SIGNED 7/1/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-2-1955	24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 7-1-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Wagner Funeral Home	ADDRESS K.C. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

H/1-6888

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 *Alvin R. Haunschedel*

Licensed Embalmer No. *41*

P. O. Address *K. C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.