

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36010

STATE FILE NUMBER

Health,  
& Welfare  
Public  
ServiceRegistration District No. 149 Primary Registration District No. 1.002 Registrar's No. 4553S. 300  
7. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

John B. Justus

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>912 LOCUST</u> Length of stay in (b) <u>24 YRS</u>		d. STREET ADDRESS (If outside, give location) <u>912 LOCUST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>MILLER</u> Middle <u>MILLER</u> Last		4. DATE OF DEATH <u>9-28-1957</u> Month <u>9</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1891</u>
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>ST. PETERS, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN MILLER</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA ONE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>---</u>	
16. SOCIAL SECURITY NO. <u>487-01-1376A</u>		17. INFORMANT <u>W<sup>M</sup> Miller</u> Address <u>3744 GARNER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary emphysema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchial asthma</u> DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 1/2</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>		20c. TIME OF INJURY Hour <u>---</u> Month <u>---</u> Day <u>---</u> Year <u>---</u> a. m. <u>---</u> p. m. <u>---</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. CITY, TOWN, OR LOCATION <u>---</u> COUNTY <u>---</u> STATE <u>---</u>		21. I attended the deceased from <u>Sept. 1953</u> to <u>Sept. 1957</u> and last saw <u>him</u> alive on <u>July, 1957</u> . Death occurred at <u>8 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree & title) <u>John B. Justus M.D.</u>		22b. ADDRESS <u>4620 Nichols Pkwy. K.C., MO</u>	
22c. DATE SIGNED <u>9-30-57</u>		23a. BURIAL, CREMATION, OR TREATMENT (Specify) <u>BURIAL</u>	
23b. DATE <u>10-1-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CAIVARY CEM.</u>	
23d. LOCATION (City, town, or county) <u>KANSAS CITY, MO</u>		23e. (State) <u>---</u>	
24. FUNERAL DIRECTOR <u>PASSANTINO BROS KE, MO</u> ADDRESS <u>---</u>		25. DATE RECD. BY LOCAL REG. <u>10-1-57</u>	
26. REGISTRAR'S SIGNATURE <u>new Minshall</u>		27. (Licensed Embalmer's Statement on Reverse Side)	

Dr. O. Brien  
4620 S. E. Nickel Parkway  
2 PM  
Je 11500

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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 *Leonard Passantino*.....

Licensed Embalmer No. *455*

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