

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018382
STATE FILE NUMBER

MAY 23 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2324

300
1-57

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, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2939 FOREST AVE		Length of stay in lb 31 yrs.	d. STREET ADDRESS (If outside, give location) 2939 FOREST AVENUE Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MIDDLE Last LEDA GURITH MILLER			4. DATE OF DEATH Month Day Year MAY - 5 - 1958		
---	--	--	--	--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH - 1 - 1887	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
------------------	---------------------------	---	--------------------------------------	---------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) APARTMENT HOUSE MGR.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) CENTRALIA, MO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	--	--

13a. FATHER'S NAME JAMES A. MILLER	13b. MOTHER'S MAIDEN NAME LENNIE BROWN	14. NAME OF HUSBAND OR WIFE BRUCE SPIVE
---------------------------------------	---	--

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. 486-05-6859	17. INFORMANT MRS. ELWOOD WILSON - KANSAS CITY, MO.	Address 6010 PARK AVENUE
---	--	--	-----------------------------

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> cerebral apoplexy </u>		INTERVAL BETWEEN ONSET AND DEATH <u> 24 hours </u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u> myocarditis - </u>		<u> 6 years </u>
	DUE TO (c) <u> arteriosclerosis </u>		<u> 5 years </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4221		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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.)
---	--

20c. TIME OF INJURY Hour a.m. p.m.	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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
---------------------------------------	--	--	------------------------------	--------	-------

21. I attended the deceased from <u> 1-19-52 </u> to <u> 5-5-58 </u> and last saw her/him alive on <u> 5-3-58 </u> . Death occurred at <u> 6:10 P. </u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u> Dr. J. J. Critten </u> (Degree or title)	22b. ADDRESS <u> 3119 Troost St. KCMo </u>	22c. DATE SIGNED <u> 5/6/58 </u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
<u> Cremation </u>	<u> 5-7-58 </u>	<u> Newcomer's Home </u>	<u> Kansas City, Mo. </u>	

24. FUNERAL DIRECTOR <u> D.W. NEWCOMERS </u>	ADDRESS <u> 1331 BRUSH CREEK </u>	25. DATE RECD. BY LOCAL REG. <u> 5-7-58 </u>	26. REGISTRAR'S SIGNATURE <u> Neva Minshall </u>
---	--------------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J. J. Critten

NOV 2 1958

2

7616
12003

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 *Norman W. Houston*

Licensed Embalmer No. 4889

P. O. Address N.C. Fla.

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.