

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 4 1959

59-029206

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4048 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Length of stay in 1b <u>70 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> c. CITY OR TOWN <u>Kansas City</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1319 E. 32nd St. Terr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1959</u>				
5. SEX <u>Female</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>5-17-79</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bayles Dist. Co.</u>		11. BIRTHPLACE (City and state or country) <u>Schuylkill County, Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William A. Miller</u>			13b. MOTHER'S MAIDEN NAME <u>Emma L. Wannemacher</u>		14. NAME OF HUSBAND OR WIFE <u>Never Married</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>486-09-8969A</u>		17. INFORMANT <u>Ida Allen</u> Address <u>1214 N. 18th, K. C. Ks.</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>Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Mixed fungi</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Poisoning - Chronic invalid</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <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.)			20f. CITY, TOWN, OR LOCATION COUNTY STATE				
21. I attended the deceased from <u>1951</u> , to <u>8-18-59</u> and last saw her/him alive on <u>8-18-59</u> . Death occurred at <u>4:10</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>William Lane Mundy M.D.</u>			22b. ADDRESS <u>1103 Grand</u>		22c. DATE SIGNED <u>8-20-59</u>		
23a. MANNER OF CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Stine & McClure, Kansas City, Missouri</u>			25. DATE RECD. BY LOCAL REG. <u>8-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Nevar Marshall</u>		

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF William Lane Mundy

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.