RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 25 1959

59-032482

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4387

DED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Mo — Length of stay in 1b 8 yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 8420 Wornall Rd — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City Mo — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 8420 Wornall Rd — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Carl Middle M Last Miller

4. DATE OF DEATH Month 9 Day 6 Year 1959

5. SEX male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 11-2-1894
9. AGE (last birthday) 64 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

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

13a. FATHER'S NAME —
13b. MOTHER'S MAIDEN NAME —
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 497-14-9036
17. INFORMANT A.N. Rice — Address 8420 Wornall Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Geo C. Kealhofer Deputy Coroner
22b. ADDRESS 6627 Prospect Sc Cin
22c. DATE SIGNED 9-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 9-10-59
23c. NAME OF CEMETERY OR CREMATORY Mt Calvary
23d. LOCATION (City, town, or county) Kansas City (State) Kansas

24. FUNERAL DIRECTOR France-Wornall Funeral Home — ADDRESS
25. DATE RECD. BY LOCAL REG. 9-9-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Geo C. Kealhofer

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_____ Signed Russell N. Franc

Signature of Student Embalmer

Licensed Embalmer No. 425

P. O. Address K. C. M

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