

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-006440

FILED 15 FEB 23 1960

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 803

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>60 yrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</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>Mo.</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5630 Paseo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLAYTON</u> Middle <u>T.</u> Last <u>MILLER</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1886</u>	9. AGE (last birthday) <u>73</u>	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) <u>Tavern Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>		11. BIRTHPLACE (City and state or country) <u>Lewistown, Penn.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Miller</u>		13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE <u>Florence Maude Miller</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>496-32-6617 A</u>		17. INFORMANT Address <u>Mrs. Florence Hunt, 5634 Paseo</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>Arteriosclerotic heart disease</u> DUE TO (b) <u>A</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</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 type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ Month, Day, Year _____ 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>Mar. 11 1958</u> to <u>Feb. 8 1960</u> and last saw him alive on <u>Feb. 8, 1960</u> Death occurred at <u>5:00 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Full name or title) <u>Albert I. Decker M.D.</u>			22b. ADDRESS <u>Kansas City, Missouri</u>		22c. DATE SIGNED <u>2-9-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-11-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar Funeral Home</u> <u>Woodland-Linwood</u>			25. DATE RECD. BY LOCAL REG. <u>2-10-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Albert I. Decker

Dr. Albert B.
Washington
Va. 22-670

1-5 PM
Signed

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 Melvin Bortea

Licensed Embalmer No. 490
P. O. Address R.C. M

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