

**MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-015515**

**FILED VS APR 25 1960**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1919 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>JACKSON</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		a. STATE <b>MISSOURI</b>		b. COUNTY <b>JACKSON</b>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LUKES HOSP.</b>		Length of stay in 1b <b>13 hrs.</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>10 W. 40th ST.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>Jeffery</b>		Middle <b>Allen</b>		Last <b>MILLER</b>		Month Day Year <b>APRIL 3, 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4 2 60</b>	9. AGE (last birthday)	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) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KANSAS CITY MO.</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>FRANK W MILLER</b>			13b. MOTHER'S MAIDEN NAME <b>VIRGINIA RUTH WALTERS</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>FRANK W. MILLER 10 w 40th WAY</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH <b>13 hr 45 min</b>	
IMMEDIATE CAUSE (a) <b>Prematurity</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hyaline Membrane disease</b>							
DUE TO (c)							
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. Month, Day, Year							
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>April 2, 1960</u> to <u>April 3, 1960</u> last saw him alive on <u>April 3, 1960</u> Death occurred at <u>7:55</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Raymond B Anderson M.D.</b>				22b. ADDRESS <b>411 Nichols Rd.</b>		22c. DATE SIGNED <b>4-4-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>APRIL 4 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEM</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS KC. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>4-4-60</b>	26. REGISTRAR'S SIGNATURE <b>Neve Marshall</b>		

DOCUMENT

BY AFFIDAVIT OF **Raymond B. Anderson M.D.** MEDICAL CERTIFICATION

**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 Chester K Brock

Licensed Embalmer No. 493

P. O. Address KE VA

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.