

RID DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019525

FILED VS MAY 27 1960

Registrar's District No. 149 Primary Registration District No. 1002 Registrar's No. 2377 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>45 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Osteopathic Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4825 Brooklyn</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Miller</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11-20-1883</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Lawson, Missouri</b>		11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>		
13a. FATHER'S NAME <b>John H. Cox</b>			13b. MOTHER'S MAIDEN NAME <b>Harriett Hightower</b>		14. NAME OF HUSBAND OR WIFE <b>Robert W. Miller</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>496-26-0926</b>	17. INFORMANT Address <b>Mrs. Luella Chatfield, Kansas City, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>IMMEDIATE CAUSE (a) hypostatic pneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
DUE TO (b) <b>CVA</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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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 <b>4-6-60</b> to <b>4-26-60</b> and last saw her/him alive on <b>4-25-60</b> Death occurred at <b>1:30A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>John A. Linville</i> (Degree or title)			22b. ADDRESS <b>25 E. 12th. K. C. Mo.</b>		22c. DATE SIGNED <b>4-26-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>4-28-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; Mc Clure Kansas City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>4-28-60</b>	26. REGISTRAR'S SIGNATURE <i>Neve Minshall</i>			

DOCUMENT

John A. Linville MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*William M. Jones*

Licensed Embalmer No. 468

P. O. Address Kansas City

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.