

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042155

FILED VS DEC 1 2 1960

Registration District No. 149 Primary Registration District No. 1005 Registrar's No. 5824 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> 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>57 yrs.</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>639 E. 74th Terrace</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CELIA</u> Middle <u>MILLER</u> Last <u>MILLER</u>			4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>Female</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>Approx 75 yrs.</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>75</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (City and state or country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jehudah Snitz</u>		13b. MOTHER'S MAIDEN NAME <u>Leah (Not Known)</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Miller (d'c'd)</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>--</u>	17. INFORMANT Address <u>Eunice Dworkin, 639 E 74 Terr, K.C.</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>Metastatic Rhabdomyosarcoma.</u> DUE TO (b) <u>Rhabdomyosarcoma, arm, amputated.</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		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. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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.) <u></u>
20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>		

21. I attended the deceased from 7-28-59 to 11-19-60 and last saw her/him alive on 11-19-60. Death occurred at 12:5 PM. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Jack C Vincent, MD.</u>	22b. ADDRESS <u>701 E 63 15C Mo.</u>	22c. DATE SIGNED <u>11-19-60</u>
---	--------------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/20/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sheffield</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>J.P. Louts Funeral Home, K.C., Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-19-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>
--	--	--

DOCUMENT

MEDICAL CERTIFICATION
Jack C. Vincent

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 *Greg Buffington*
Licensed Embalmer No. 2758

P. O. Address K.C. Mo

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.