SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 062 Registrar's No. 3330 -61-025370 STATE FILE NUMBER

AMENDED

FILED JUL 26 1961

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY — Length of stay in 1b: 1 YR.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: KELLY NURSING HOME — 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 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4123 INDEP AVE — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: JOHN Middle: L. Last: MILES
4. DATE OF DEATH: Month 7 Day 1 Year 61
5. SEX: M
6. COLOR OR RACE: W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2/26/77
9. AGE (last birthday): ~~85~~ 84 — 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): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: LAW ENFORCEMENT
11. BIRTHPLACE (City and state or country): TENN
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: GEORGE MILES
13b. MOTHER'S MAIDEN NAME: UNK.
14. NAME OF HUSBAND OR WIFE: NONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): SPANISH AMERICAN, WWI
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: KELLY NURSING HOME Address: 4123 INDEP AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Nephritis, chronic; due to, — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis, generalized — 20 yrs
DUE TO (c) Uremia — 1-2 wks

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.) X
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year X
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 1959 to 6/30/61 and last saw him alive on 6/30/61
Death occurred at 7-1-61 @ 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): L. E. Riller M.D.
22b. ADDRESS: K.C. Mo
22c. DATE SIGNED: 7/4/61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 7/5/61
23c. NAME OF CEMETERY OR CREMATORY: WOOD LAWN
23d. LOCATION (City, town, or county) (State): INDEPENDENCE MO.

24. FUNERAL DIRECTOR: OTT & MITCHEL ADDRESS: INDEP MO.
25. DATE RECD. BY LOCAL REG.: 7-4-61
26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF | MEDICAL CERTIFICATION | L. E. Riller

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3625

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.