

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033013

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 449

Primary Registration District No. 1002

Registrar's No. 4519

AMENDED

FILED SEP 25 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 55 YEARS	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WALNUT NURSING HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8520 HIAWATHA ROAD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CHARLES ALEX MILLER			4. DATE OF DEATH Month Day Year SEPTEMBER 8th 1961		
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-10-68	9. AGE (last birthday) 92	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired Salesman		11. BIRTHPLACE (City and state or country) QUINCY ILLINOIS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME WILLIAM. F. MILLER		13b. MOTHER'S MAIDEN NAME MAGDALENE MAGADELENE-RUFF		14. NAME OF HUSBAND OR WIFE MRS. ALICE A. MILLER	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service.) YES SPANISH-AMERICAN		17. INFORMANT KANSAS CITY MO MRS. ROBERT ANDERSON, 8520 HIAWATHA	
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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 22 Hrs
IMMEDIATE CAUSE (a) Cerebral Hemorrhage			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis + Hypertension.		
DUE TO (c) Senility changes.			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Prostate.		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	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 1955 to 9-8-1961 and last saw him alive on 7 Sept. 1961
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wallace H. Graham M.D.	22b. ADDRESS 518 Argyle Bldg. N.C. Mo	22c. DATE SIGNED 9 Sept. 61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT. 11, '61	23c. NAME OF CEMETERY OR TOMB MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons Kansas City Mo	25. DATE RECD. BY LOCAL REG. 9-11-61	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Wallace H. Graham

ITEM NO. SHOULD READ

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 Vern Lawler

Licensed Embalmer No. 4915

P. O. Address K. G. M.

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.