

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006830

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 882 STATE FILE NUMBER

FILED FEB 26 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	DATE AMENDED	1	3	4	5	6	7	8	10	11	12	13
3438		6	1	2	94201	86-0						

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF John K. Caldwell

ITEM NO. SHOULD READ

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> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay: in 1b <u>20 yrs</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>Beacon Hill Nursing Home</u> <u>2905 Campbell</u>		d. STREET ADDRESS (If outside, give location) <u>2705 Charlotte</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE A. MILLER</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1881</u>
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Maysville, Kentucky</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Louis Miller</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Pretzinger</u>		14. NAME OF HUSBAND OR WIFE <u>None</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 <u>L. V. Midicus, 600 Independence</u>		Address <u>Summit, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)		<u>Myocardial Degeneration</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>			
DUE TO (b)		<u>Coronary Atherosclerosis</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Thrombosis</u> <u>1 year</u>			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 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>Mar 1, 1962</u> to <u>Feb 8, 1963</u> and last saw him alive on <u>Feb 2, 1963</u> Death occurred at <u> </u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John K. Caldwell MD</u> (Degree or title)		22b. ADDRESS <u>306 E. 12 St</u> <u>Kansas City, Mo.</u>	22c. DATE SIGNED <u>2/8/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1963</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) <u>Maysville, Kentucky</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mellody-McGilley-Eylar Funeral Home</u> <u>Woodland-Linwood</u>		25. DATE RECD. BY LOCAL REG. <u>2-9-63</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

USE BLACK INK OR TYPEWRITER RIBBON.

Dr. Caldwell
Argyle Bldg

3:00 - 6

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. _____

P. O. Address _____

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.