

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31909

State File No. _____
Registrar's No. **4438**

FILED OCT 6 1953

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 30 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		e. STREET ADDRESS (If rural, give location) 1001 Locust Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Otis	b. (Middle) O.	c. (Last) Miller	4. DATE OF DEATH (Month) (Day) (Year)	9 6 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 2	8. DATE OF BIRTH 4-7-1885	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar Packer	10b. KIND OF BUSINESS OR INDUSTRY Niles-Moser Cigar Co.	11. BIRTHPLACE (City and State or Foreign Country) Unknown	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Record Clerk-KC General Hospital	ADDRESS General Hospital
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral confluent bronchopneumonia with abscess formation		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **August 7, 1953**, to **Sept. 6, 1953**, that I last saw the deceased alive on **Sept. 6, 1953**, and that death occurred at **8:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns, M.D.	B.I. Burns (Degree or title)	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 9-8-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-10-1953	24c. NAME OF CEMETERY OR CREMATORY Mount Galvary	24d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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DATE REC'D BY LOCAL REG. 9-10-53	REGISTRAR'S SIGNATURE Seraldine Smith	25. EMERALD DIRECTOR'S SIGNATURE B.C. Weiler, L.C.S.M.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Clinge

1210 12

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..... *B. E. Weir*

Licensed Embalmer No. *4075*

P. O. Address *F. C. S. Mc*

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.