

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

23534

**1. PLACE OF DEATH**

County Jackson Registration District No. 5002  
Towship Raw Primary Registration District No. 5002  
City Kansas City (No. 4552 Mission)

File No. 3268  
Registered No. 3268  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Robert E. Myers

(a) Residence. No. 4552 Mission St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Minnie Myers</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 9 1888</u>		
7. AGE YEARS <u>35</u>	MONTHS <u>8</u>	DAYS <u>16</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Officer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Police Dept</u> (c) Name of employer <u>K. C. Mo</u>		
9. BIRTHPLACE (CITY OR TOWN) <u>New York</u> (STATE OR COUNTRY) <u>New York</u>		
10. NAME OF FATHER <u>Wm J. Myers</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>R. I.</u> (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER <u>Liddle Perkins</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>R. I.</u> (STATE OR COUNTRY)		
14. INFORMANT <u>Benj. Myers</u> (Address) <u>1726 Dodd St.</u>		
15. FILED <u>8/30 1924</u> <u>M. M. Kerue</u> REGISTRAR		

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 28 19 24

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1924 to Aug 28, 1924, that I last saw him alive on Aug 28, 1924, and that death occurred, on the date stated above, at 11:45 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Brain-fever  
(Cerebellum)  
860 (duration) yrs. mos. da. 3 da.

CONTRIBUTORY had middle ear abscess  
(SECONDARY)  
operated by Dr. Miller (duration) yrs. mos. da. 2 mos. da.

18. WHERE WAS DISEASE CONTRIBUTORY  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF 4th of July  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) H. B. Carter & H. A. Reisinger, M. D.  
8/28, 1924 (Address) Ridge Bldg 4 Hyde Park Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Maple Hill</u>	DATE OF BURIAL <u>8-30 1924</u>
20. UNDERTAKER <u>H. W. Gates</u>	ADDRESS <u>K. C. Mo.</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide, Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENT  
BY PHYSICIAN.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**1. PLACE OF DEATH**

County Jackson Registration District No. 999 File No. 235-34  
 Township Rau Primary Registration District No. 1002 Registered No. 3268  
 City Kansas City St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Robert E Myers

(a) Residence No. 4552 Meier St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 28, 1924

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) Mrs Minnie Elizabeth Myers

17. I HEREBY CERTIFY That I attended deceased from July 24, 1924, to Aug 28, 1924 that I last saw him alive on Aug 28, 1924, and that death occurred, on the date stated above, at 11:20 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10, 1887

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS 36 MONTHS 8 DAYS 18 If LESS than 1 day, 6 hrs. or min.

Brain fever  
Inflammation of  
left frontal region  
(duration) yrs. mos. ds. 3

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Police Officer  
 (b) General nature of industry, business, or establishment in which employed (or employer) City Hall  
 (c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) Had 2 operations on ear with infection  
 (duration) yrs. mos. ds. 2

9. BIRTHPLACE (CITY OR TOWN) Rochester (STATE OR COUNTRY) New York

18. WHERE WAS DISEASE CONTRACTED at home  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF July 4th  
 WAS THERE AN AUTOPSY? No

10. NAME OF FATHER William Myers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rochester (STATE OR COUNTRY) New York

12. MAIDEN NAME OF MOTHER Edith Mahalia Perkins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Gregg (STATE OR COUNTRY) New York

WHAT TEST CONFIRMED DIAGNOSIS? Spec  
 (Signed) E. H. Zuberger, M. D.  
 \_\_\_\_\_, 19 (Address) K.C. Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT Mrs Minnie E. Myers (Address) 717 Lake Ave Hospital Kansas

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Hill - Rose Dale DATE OF BURIAL \_\_\_\_\_

15. FILED 8/30 1924 M. H. Broome REGISTRAR

20. UNDERTAKER H. W. & Mrs. M. L. Gates ADDRESS State Line

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY  
 REGISTERED  
 AUG 28 1924

X. E. X.

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