

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **1109**

Registration District No. **392**

Primary Registration District No. **1002**

Registrar's No. **69**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **K.C. General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Mo. & 8 days**
(Specify whether
In this community **10 yrs**
years, months or days)

3. (a) PRINT FULL NAME **Pinkney Myers.**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **Jan 2 1895**
(Month) (Day) (Year)

8. AGE: Years **95** Months **0** Days **2** If less than one day **—** hr. **—** min.

9. Birthplace **Fredricksville Pa. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer, Retired**

11. Industry or business

MOTHER FATHER
12. Name **Pinkney Graham Myers**
13. Birthplace **Fredricksville Pa. 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Martha Robinson**
15. Birthplace **Comanche Texas 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **R.A. Acuff**
(b) Address **2411 1/2 Troost**

17. (a) **Removal** (b) Date thereof **Jan 7 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: **Maple Park Cem Springfield Mo**
(Burial or cremation)

18. (a) Signature of funeral director **M. C. Foster**
(b) Address **718 Brooklyn R.C. Mo**

19. (a) **Jan 6 1941** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson 110**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL") **3**
(d) Street No. **2411 1/2 Troost Apt. 215**
(If rural, give location) **8**
(e) If foreign born, how long in U. S. A.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **5th**
year **1941** hour **10** minute **55 P.** M.

21. I hereby certify that I attended the deceased from **11-28-40** 19, to **1-5-41** 19, that I last saw him alive on **1-5-41** 19, and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic bronchopneumonia**

Due to **Cardiac decompensation**

Due to **—**

Other conditions **ASC**
(Include pregnancy within 3 months of death)

Major findings: Of operations **—**

Of autopsy **None**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **—**
(b) Date of occurrence **—**
(c) Where did injury occur? (City or town) (County) (State) **—**
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **—**

While at work? (Specify type of place) (c) Means of injury **—**

23. Signature **Quincy R. Thon** (M. D. or other) **0**
Address **Med. Dir. K.C. Gen. Hospital** Date signed **1-6-41**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Gerald I. Wade

Licensed Embalmer No. *4172*

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 this body is not embalmed, above space should be left blank.