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5-17-39  
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DEPARTMENT OF COMMERCE

BUREAU OF VITAL STATISTICS

FILED SEP 22 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30238  
3615

State File No.

Registrar's No.

Registration District No. 147

Primary Registration District No. 1002

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 4209 Harrison  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
In this community 3 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME Pearl Myers

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Meyer 6. (c) Age of husband or wife if alive Not known years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years 90 Months Days If less than one day hr. min.

9. Birthplace 4 Roland (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER { 12. Name Carl Gershon  
13. Birthplace Roland (City, town, or county) (State or foreign country)  
14. Maiden name Not known  
15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant Morris Myers  
(b) Address K. C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-44 (Month) (Day) (Year)

(c) Place: burial or cremation Sheffield Lem.

18. (a) Signature of funeral director J. F. Lewis Funeral Home

(b) Address K. C. Mo.

19. (a) 9-6-44 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City (If outside city or town limits, write "RURAL")  
(d) Street No. 4209 Harrison (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 11

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 5 year 44 hour minute M.

21. I hereby certify that I attended the deceased from 19... to 19... that I last saw her alive on Sept. 5 and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis of hemiplegia due to cerebral hemorrhage.

Due to

Due to 8:30

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (e) Means of injury

23. Signature May Ledman (M. D. or other) Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Max Goodman Prof.

**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

*R. L. Lewis*

Licensed Embalmer No. *3110*

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, fact should be so stated above.**