

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31775

State File No.

4089

FILED SEP 27 1952

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4089</u>	
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, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>45 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>2612 Bales</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hospital</u>				3. NAME OF DECEASED a. (First) <u>James</u> (Type or Print) b. (Middle) <u>W.</u> c. (Last) <u>Myers</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 15, 1952</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Aug. 25, 1870</u>		9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie Myers</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>492-28-5549</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bessie Myers 2612 Bales K.C., Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Intertrochanteric Fracture, Left Hip</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u> <u>4201</u> <u>12 wks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Intertrochanteric Fracture, Left Hip</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>July 6, 1952</u> , to <u>Sept 15, 1952</u> , that I last saw the deceased alive on <u>Sept 15, 1952</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W. H. Brust MD</u>				23b. ADDRESS <u>106 W. 1st St. K.C., Mo.</u>		23c. DATE SIGNED <u>Sept 16 1952</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/17/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-16-52</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Earp & Sons 4139 Truman Rd. K.C., Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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 this body is not embalmed, fact should be so stated above.