

FILED SEP 20 1954

STANDARD CERTIFICATE OF DEATH

29881

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 979

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph		c. LENGTH OF STAY (in this place) 36 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		117
d. FULL NAME OF HOSPITAL OR INSTITUTION Methodist Hospital (Missouri)			d. STREET ADDRESS (If rural, give location) 3118 North 10th Street		

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) MALCOLM c. (Last) MYERS			4. DATE OF DEATH (Month) (Day) (Year) Sept. 7 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 26, 1880		9. AGE (In years last birthday) 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stowman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Decatur County, Kansas		12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME William H. Myers		13b. MOTHER'S MAIDEN NAME Anna Fair		14. NAME OF HUSBAND OR WIFE Mrs. Ora Myers	
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. 707-07-0758		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ora Myers	
				ADDRESS St. Joseph, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure					3 wks
ANTECEDENT CAUSES		DUE TO (b) Myocardial Insufficiency from Arteriosclerosis An Sever			Months
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Severe toxemia from gangrene.			6 wks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Hist of Gout.			2 yrs
19a. DATE OF OPERATION 9-2-54		19b. MAJOR FINDINGS OF OPERATION Amputation Rt Leg -			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) 1501	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 7-11, 1954, to 9-7-54, that I last saw the deceased alive on 9-7, 1954, and that death occurred at 1:45P m., from the causes and on the date stated above.

23a. SIGNATURE R. W. Kieber, M.D.		(Degree or title)	23b. ADDRESS St. Joseph, Mo		23c. DATE SIGNED 9-8-54
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24a. BURIAL CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 9, 1954	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph Missouri		
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DATE REC'D BY LOCAL REG Sept 13, 1954	REGISTRAR'S SIGNATURE Eather M. Allison		485	25. FUNERAL DIRECTOR'S SIGNATURE Stamper Funeral Home St. Joseph, Mo		ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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.....

Charles E. Bennett

Signed.....
Student Embalmer

Licensed Embalmer No. *4677*

P. O. Address *St Joseph Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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