

pt. Health,
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S. Public
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Robert M. Myers

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 8 1958

44320
STATE FILE NUMBER
149 Primary Registration District No. 1002 Registrar's No. 5929

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1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION TRINITY LUTHERAN HOSP.		Length of stay in 1b 30 YEARS	
3. NAME OF DECEASED (Type or print) First JULIA Middle DENT Last DUNIVENT		4. DATE OF DEATH DEC. 14, 1957	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 10, 1885	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - AT HOME DOMESTIC		11. BIRTHPLACE (City and state or country) CLIFTON HILL MISSOURI	
13a. FATHER'S NAME JOSEPH W. SWEENEY		13b. MOTHER'S MAIDEN NAME SUSAN E. SCRIMPsher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT DAVE DUNIVENT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition - malnutrition		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ca of Cervix & Pelvis		Yrs	
DUE TO (c) also Ca of G.B & liver		191X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) (Both Ca apparently primary)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1937 to 13 Nov 57 and last saw her alive on 13 Nov 57 Death occurred at 2:05A. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Robert M. Myers M.D.	
22b. ADDRESS 1025 Qualto Bldg		22c. DATE SIGNED 14 Nov 57	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 16, 1957	
23c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY		23d. LOCATION (City, town, or county) (State) MOBERLY MISSOURI	
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS		25. DATE RECD. BY LOCAL REG. 12-16-57	
26. REGISTRAR'S SIGNATURE neva minshall			

22

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Vern Sewer*

Licensed Embalmer No. *4915*
P. O. Address *47 E 32nd St*

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 embalmed by a-STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.