

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034941

FILED VS OCT 1 0 1960

149

Primary Registration District No. 1002

Registrar's No. 4841

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Neosho			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1 Week		c. CITY OR TOWN Chanute Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 514 West 7th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FOSTER Middle MYERS Last MYERS			4. DATE OF DEATH Month Sept. Day 23 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1894	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Neosho, Kansas	
10c. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Faye 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. None	
17. INFORMANT Mrs. Faye Myers		Address Chanute, Kansas			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Vascular collapse DUE TO (c) Surgical repair of ventral hernia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Radical upper subtotal gastrectomy					INTERVAL BETWEEN ONSET AND DEATH
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		205. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 9-14-60 to 9-23-60 and last saw her/him alive on 9-23-60 Death occurred at 9-23-60 9:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree title) H. J. McAnally MD			22b. ADDRESS 3102 West K.C. Mo.		22c. DATE SIGNED 9-24-60
23a. BURIAL REMOVAL (Specify) Removal		23b. DATE 9-24-60		23c. NAME OF CEMETERY OR CREMATORY Memorial Park	
23d. LOCATION (City, town, or county) Chanute, Kansas		24. FUNERAL DIRECTOR Freeman Mortuary		25. DATE RECD. BY LOCAL REG. 9-24-60	
24. ADDRESS Kansas City, Mo.		26. REGISTRAR'S SIGNATURE H. L. Sawyer			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. J. McAnally

APR 7 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J. S. Freeman

Licensed Embalmer No. 293

P. O. Address F. O.

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.