

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001750

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 468 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 8 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY: Jackson		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE: Missouri COUNTY: Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City		Length of stay in lb: 11 Days	c. CITY OR TOWN: Lees Summit
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Joseph Hospital		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location): Rt. 2
3. NAME OF DECEASED (Type or print) First: MABEL Middle: MAE Last: MYERS		4. DATE OF DEATH Month: 1 Day: 23 Year: 63	
5. SEX: Female	6. COLOR OR RACE: White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH: 4/7/97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE		10b. KIND OF BUSINESS OR INDUSTRY: HOME	11. BIRTHPLACE (City and state or country): Leavenworth, Mo.
13a. FATHER'S NAME: Oscar S. Myers		13b. MOTHER'S MAIDEN NAME: Josephine Rudolph	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No		17. INFORMANT: Mrs. C.K. Melching Address: Rt. 2 - Lees Summit, Mo.	
18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, intestinal obstruction DUE TO (b) Ruptured diverticulitis DUE TO (c) Pulmonary edema, cardiac dilatation (toxic) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Carcinoma left ear - with metastases			INTERVAL BETWEEN ONSET AND DEATH: Jan 1st about
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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: _____ a.m. _____ p.m. Month: _____ Day: _____ Year: _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 Jan 12 - 1963 to Jan 23 - 1963 and last saw her alive on Jan 23 '63 . Death occurred at 7:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title): Vincent J. Williams M.D.		22b. ADDRESS: 836 Maple Blk - KC Mo.	
22c. BURIAL, CREMATION, REMOVAL (Specify): Removal		22d. DATE SIGNED: Jan 24 - 63	
23b. DATE: 1/23/63		23c. NAME OF CEMETERY OR CREMATORY: St. Muncie Unknown	
24. FUNERAL DIRECTOR: Larkin Funeral Home ADDRESS: -Leavenworth, Kans.		25. DATE RECD. BY LOCAL REG.: 1-24-63	
26. REGISTRAR'S SIGNATURE: A. Keith Long			

USE BLACK INK OR TYPEWRITER RIBBON

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 L. L. Larkin

Licensed Embalmer No. 1862

P. O. Address Leaw, Kans.

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.