

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-63-006825**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 643

**FILED FEB 8 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

George K. Boyd

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri; COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>25 Yrs</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>8100 Wornall Road</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8100 Wornall Road</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Lola Meyer</b>		First Middle Last	4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-16-1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (last birthday) <b>84 Yrs</b> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) <b>Winfield Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Marcus Bangs</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Dunn</b>	
14. NAME OF HUSBAND OR WIFE <b>Albert H. Meyer</b>		17. INFORMANT Address <b>Raytown</b> <b>Mrs. Raymond Lamar 9403 E. 65th</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No No</b>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Infarction</b> DUE TO (c) <b>Cerebral-Vascular Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 week</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Inanition</b>		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"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 <b>Jan 19 60</b> to <b>present</b> and last saw her alive on <b>1-28-63</b> Death occurred at <b>7:00 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>George K Boyd MD</b> (Degree or title)		22b. ADDRESS <b>5111 Independence Ave</b>	
22c. DATE SIGNED <b>1-31-63</b> (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-2-1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION (City, town, or county) <b>Kansas City Kansas</b>	
24. FUNERAL DIRECTOR <b>Stine &amp; McClure Kansas City, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>1-31-63</b>	
		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

USE BLACK INK OR TYPEWRITER RIBBON

29. # 100-100-100  
340

Rev. George K. Boyd  
Ba. 1-7943  
5111 Indigo Ave  
St. Joseph, Mo.

**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

*Tracy M<sup>c</sup>Curdy*

Licensed Embalmer No. 5125

P. O. Address Kansas City, Mo.

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.