

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028551

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3600 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

FILED JUL 22 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Length of stay in lb <b>53 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>1012 Newton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1012 Newton</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>FELIX MYERS</b>			4. DATE OF DEATH <b>June 25 1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White Married</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-1890</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Logan Moore Lbr.</b>	11. BIRTHPLACE (City and state or country) <b>Indiana</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John Myers</b>	13b. MOTHER'S MAIDEN NAME <b>Liza Hall</b>	14. NAME OF HUSBAND OR WIFE <b>Elsie Mae Myers</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown.) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>[Redacted]</b>	17. INFORMANT <b>Elsie Myers, 1012 Newton, K.C.Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Asphixia</b> DUE TO (c) <b>Tuberculosis</b>		Terminal Bronchopneumonia Right Heart Failure Chronic Adhesive Pleurisy Tuberculosis	INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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.	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 1959 to June 25 63 and last saw him live on June 25, 1963  
Death occurred on June 25, 1963 at 1 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	Degree or title	22b. ADDRESS <u>3011 [Redacted] Ave.</u>	22c. DATE SIGNED <u>6/26/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <u>6-28-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>Sheil Funeral Home, Kansas City, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-27-63</u>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

ITEM NO.	SHOULD READ	DATE AMENDED
1		7/26/63
2		7/26/63
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

VS 300 Rev. 4/59

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51,40

1290-2

Terminal bronchial pneumonia cardiac arrest  
Right heart failure Asphixia  
Chronic adhesive pleurisy Tuberculosis

BY AFFIDAVIT OF Attending physician  
Calvin Pilger MEDICAL CERTIFICATION

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 Jimmy S. Birch

Licensed Embalmer No. 5212

P. O. Address K.C., 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.