

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044162
STATE FILE NUMBER

Registration District No. 199 Primary Registration District No. 1002 Registrar's No. 5868

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 21 1963	
1. PLACE OF DEATH	
a. COUNTY Jackson	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 20 Years c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lakeside Hospital	d. STREET ADDRESS (If outside, give location) 1611 East 36th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Middle Last	
ORA B. MYERS	
4. DATE OF DEATH October 28 1963	
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 6-22-1888
9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME John Neaser	13b. MOTHER'S MAIDEN NAME Elizabeth Jones
14. NAME OF HUSBAND OR WIFE Almon L. Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No	16. SOCIAL SECURITY NO. [Redacted]
17. INFORMANT Mrs. Lona Hockaby 1611 East 36th	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) terminal hypertensive pneumonia	INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Renal Insufficiency	3 yrs
DUE TO (c) Generalized Arteriosclerosis	
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 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 July-1961 Oct-28-63 and last saw him alive on Oct-28-1963	
Death occurred at 6:15 P m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) E. L. Gehrke	22b. ADDRESS 1400 E 23rd St KC Mo
22c. DATE SIGNED 10/29/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-31-63
23c. NAME OF CEMETERY OR CREMATORY Lathrop Cemetery	23d. LOCATION (City, town, or county) (State) Lathrop, Missouri
24. FUNERAL DIRECTOR Muehlebach ADDRESS 6800 Troost	25. DATE RECD. BY LOCAL REG. 10-29-63
26. REGISTRAR'S SIGNATURE Bessie Smith	

VS 300 Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1400 1/2 E. 31
Dr. Gehlke

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 Robert L. Landes

Licensed Embalmer No. 5103

P. O. Address A. C. Mc.

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.