

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30480

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. _____
 Township Daw Primary Registration District No. _____ Registered No. 7
 City Kansas City (No. T.C. General Hosp) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1428 Locust St. 7 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 8 yrs. 2 mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elvira Myers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 9 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 | 11 | 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Hall Myers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Amelia Perkins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Deirda Clark
 (Address) T.C. General Hosp

15. FILED 10-22-27 M.M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-21 1927

17. I HEREBY CERTIFY That I attended deceased from 7-8 1927 to 10-21 1927 that I last saw him alive on 10-21 1927, and that death occurred, on the date stated above, at 4:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Prostate
with metastases
51C
109H (duration) yrs. mos. ds.

CONTRIBUTORY Hypostatic Pneumonia
 (SECONDARY) (Broncho) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IND AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) George O. Lee M. D.
10-22 1927 (Address) General Hosp T.C. Hosp

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Waldron DATE OF BURIAL 10-23 1927

20. UNDERTAKER Mrs L. Foster ADDRESS 94 Bowler

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

