

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

Do not use this space.

23203

1. PLACE OF DEATH

County Jackson
Township Excise
City (No. _____) _____

Registration District No. 405
Primary Registration District No. 55570

File No. _____
Registered No. 95
St. _____ Ward _____

2. FULL NAME Henry Myers

(a) Residence. No. 9 Johnson Beauty Stone Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 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)

Single

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

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

2-10-1860

7. AGE

YEARS 70

MONTHS 5

DAYS -

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) New Jersey

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14.

INFORMANT J. W. Ketterer
(Address) Jackson Coffman

15.

FILED 7-17-30 H. S. James
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-10-1930

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930 to 7/10, 1930
that I last saw him alive on 7-10, 1930 and that death occurred, on the date stated above, at 11:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic myocarditis

73C

(duration) yrs. mos. ds.

CONTRIBUTOR (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Ketterer, M. D.

7/11, 1930 (Address) 242 S. 1st St.

*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

DATE OF BURIAL

Kennel Cemetery 7-17 1930

20. UNDERTAKER

ADDRESS

Ketterer Funeral Home

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.

AUG 26 1930

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