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

Do not use this space 30140

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. ..... Mercy Hosp. St. ..... Ward)

Registration District No. 399
Primary Registration District No. 1002

File No. 3948
Registered No.

2. FULL NAME Clara Myers
(a) Residence. No. 615 E 8th st. apt B, K.C. Mo. 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 5/16/17

7. AGE: Years 13 | Months 4 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Kansas

PARENTS
10. NAME OF FATHER Orville Myers
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Eunice Brink
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Nebraska

14. INFORMANT Mrs Eunice Myers
(Address) 615 E 8th st

15. FILED 9/27, 1930 M M Crowl
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 25 1930

17. I HEREBY CERTIFY, That I attended deceased from 9/22/30, 19..., to 9/25/30, 19..., that I last saw h. on alive on 9/25/30, 19..., and that death occurred, on the date stated above, at 9:25 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
825 Traumatic Abscess of
158 Nasal Septum
174 (Scratch)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Erysipelas & Thrombosis of Cavernous Sinuses
(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH At home
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Exam & Lab
9/26, 1930 (Signed) W M Howard, M. D.
(Address) Mercy 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: Woodlawn K.C. Mo
DATE OF BURIAL: 9-27 1930

20. UNDERTAKER: Porter & Eads
ADDRESS: K.C.

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.