

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson Registration District No. 398  
Township Blue Primary Registration District No. 3019  
City Independence (No. Independence Sanitarium)

File No. 9713  
Registered No. 96  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Betty Lou Myers

(a) Residence. No. Independence Sanitariums, 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-8-1931

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, ... hrs. or ... min.
	0	0	0	

**8. OCCUPATION OF DECEASED**

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

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

**PARENTS**

10. NAME OF FATHER Homer C. Myers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Williamsburg,  
(STATE OR COUNTRY) W. Va.

12. MAIDEN NAME OF MOTHER Vivian H. Otte.

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

14. INFORMANT Homer C. Myers  
(Address) Kentucky - Hedges

15. FILED 3-9-1931 JR Cash  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-8-1931 19

17. I HEREBY CERTIFY, That I attended deceased from 3-8-1931, 1931, to 3-8-1931, 1931, that I last saw her alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Premature Birth

CONTRIBUTORY (SECONDARY) 159 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

18. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) Chas E. McKesson, M. D.

3. 9. 1931 (Address) Independence Mo.

\*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 Mt. Washington DATE OF BURIAL 3-9-1931

20. UNDERTAKER H. W. Stahl. ADDRESS Indep. Mo.

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.

APR 23 1931

WHITE LABEL, WITH ENVELOPING BACK THIS IS A PERMANENT RECORD

