

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.

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

Do not use this space.

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1. PLACE OF DEATH  
 11 County Buchanan Registration District No. 85  
 5 Township St Joseph Primary Registration District No. 1001  
 City St Joseph (No. ....) St. .... Ward)

2. FULL NAME John O Myers  
 (a) Residence, No. 207 7/2 Wheeling Ward. 207 7/2 Wheeling, Kansas City, Mo  
 (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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 1 1859

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>74</u>	<u>7</u>	<u>0</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. conductor

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Mo. Pacific R.R

10. Date deceased last worked at this occupation (month and year) unknown 11. Total time (years) spent in this occupation 25 yr

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

FATHER

13. NAME unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Records Dept Hosp #2 St Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Kansas City Mo 7-2-33

19. UNDERTAKER (ADDRESS) Mrs C. L. Faraster Kansas City Mo

20. FILED 7-1-33 John R. Bendure Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 1 1933

22. I HEREBY CERTIFY, That I attended deceased from Apr 6 1932 to July 1 1933  
 I last saw him alive on July 1 1933 Death is said to have occurred on the date stated above, at 10:05 a.m.  
 The principal cause of death and related causes of importance were as follows:

<u>Broncho-Pneumonia</u>	<u>2 day</u>
<u>Chronic Nephritis</u>	<u>1 1/2 yr</u>
<u>Chronic Myocarditis</u>	<u>1 yr</u>

Other contributory causes of importance:  
Chronic Nephritis Sept 7 '31  
Chronic Myocarditis " "

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? Yes  
 If so, specify .....  
 (Signed) Walter Smith M. D.  
 (Address) St Joseph Mo

