

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.

SEP 22 1937

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

Do not use this space.

31450

246  
274  
668

1. PLACE OF DEATH

County *Pettis*

Registration District No. *668*

Township

Primary Registration District No. *3032*

City *Sedalia*

(No. *1220W-11*)

File No.

Registered No.

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Catherine Rosetta Myers*

(a) Residence, No. *1220W-11* St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *30* 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) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *William H. H. Myers*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb. 28 1860*

7. AGE YEARS *77* MONTHS *5* DAYS *21* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

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

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

12. BIRTHPLACE (CITY OR TOWN) *Jefferson City* (STATE OR COUNTRY) *Missouri*

13. NAME *Dennis Sullivan*

14. BIRTHPLACE (CITY OR TOWN) *Ireland* (STATE OR COUNTRY)

15. MAIDEN NAME *Mary Cronin*

16. BIRTHPLACE (CITY OR TOWN) *Ireland* (STATE OR COUNTRY)

17. INFORMANT *Katherine Lavender* (ADDRESS) *St. Francis, Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Crown Hill* DATE *Aug 21 1937*

19. UNDERTAKER *M. C. Laughlin Bros* (ADDRESS) *Sedalia*

20. FILED *Aug 20 1937* *Stan Slack* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 19 1937*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 10*, 19*27*, to *Aug 19*, 19*37*

I last saw her alive on *Aug 10*, 19*27*. Death is said to have occurred on the date stated above, at *2.20 P.M.*

The principal cause of death and related causes of importance were as follows:

*Chronic myocarditis*  
*131*  
Other contributory causes of importance:  
*Senile degeneration*  
*Chronic valvular nephritis*

Date of onset  
*20 hrs*  
*1 hr*  
*do*  
*not*  
*know*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? *Chert* Was there an autopsy? *no*

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? *no*  
If so, specify \_\_\_\_\_

(Signed) *Chas. H. ...* M. D.  
(Address) *Sedalia, Mo*

