No. 2
11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECD OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31056

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3619

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menorah Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3½ Months (Specify whether years, months or days)
In this community: Non-Resident

2. USUAL RESIDENCE OF DECEASED:
(a) State: Kansas (b) County:
(c) City or town: Chanute
(If outside city or town limits, write "RURAL")
(d) Street No.: 528 N. Highland
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: SILAS S. M. MYERS P. S.
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mrs. Leota Myers
6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: Sept. 30, 1879 (Month) (Day) (Year)
8. AGE: Years 60 Months 11 Days 15 If less than one day hr. min.
9. Birthplace: Kansas (City, town, or county) (State or foreign country)
10. Usual occupation: Grocer
11. Industry or business:
FATHER 12. Name: Don't Know
13. Birthplace: Don't Know (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Don't Know
15. Birthplace: Don't Know (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. Leota Myers
(b) Address: Chanute, Kansas
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9-16-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Chanute, Kansas
18. (a) Signature of funeral director: Freeman Mortuary
(b) Address: Kansas City, Mo.
19. (a) Sept. 16, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from June 19 42 to 9. 15. 19 40 that I last saw him alive on 9. 15. 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Sarcoma of right lung.	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operation: Sarcoma of lung
Of autopsy: Emphysema right lobe

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature: T. Dr. Drury (M. D. or other)
Address: City Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by J. L. Freeman, Registered Apprentice No. ..... working under my personal supervision.

Signed J. L. Freeman

Licensed Embalmer No. 2939

P. O. Address K. O. 2410

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.