

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23992**
Registrar's No. **3031**

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
633 East Armour Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no.**
In this community **since 1880** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **633 East Armour Boulevard**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **x**

3. (a) PRINT FULL NAME

George M. Myers

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 **Widowed**
6. (b) Name of husband or wife **Laura Boyd Myers** 6. (c) Age of husband or wife if alive **dec.** years
7. Birth date of deceased **November 26 1855**
(Month) (Day) (Year)

8. AGE: Years **87** Months **7** Days **13** If less than one day **hr.** **min.**

9. Birthplace **New York** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Automatic Sprinklers**

12. Name **Phillip Myers**

13. Birthplace **Germany** (City, town, or county) (State or foreign country)

14. Maiden name **Margaret Mulcong**

15. Birthplace **Ireland** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Helen Ware**

(b) Address **633 E. Armour, Kansas City, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-12-43** (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **7-9-43** (Date received local registrar) (b) **J. E. Brown** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **9th** year **1943** hour **10:05** minute **a.** M.

21. I hereby certify that I attended the deceased from **July 9** 19**43** to **July 9** 19**43**
that I last saw him alive on **July 9** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetic Coma** Duration **1 day**

Due to **diabetes melitus** **25 yrs**

Due to **61**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 (a) about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (b) Means of injury

23. Signature **J. E. Brown** (M.D. or other)

Address **1007 East Olive** Date signed **7/11/43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

FEB 5 1948

Dr. A. B. Lieberman,
Prof. Bldg.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. Calvin Shuppert*
Licensed Embalmer No. *4179*
P. O. Address *K.C. Mo.*

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

If this body is not embalmed, fact should be so stated above.