S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1945

STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 40259

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5334

**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: 5331 Highland Little Sisters of the Poor (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Years (Specify whether)
In this community 50 Years (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL")
(d) Street No. 5331 Highland 8 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Josephine Meyers

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) 27 (Day) 1857 (Year)

8. AGE: Years 87 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Bellview (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Wolfegang Meyers
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Little Sisters of the Poor
(b) Address 5331 Highland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1944 (Month) (Day) (Year)
(c) Place: burial or cremation St Marys Cemetery

18. (a) Signature of funeral director Fuirk and Cabel
(b) Address 20 W. Linwood

19. (a) 12-29-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 27 year 1944 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 2, 1943 to Dec 26, 1944 that I last saw her alive on Dec 26, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Uterus about 10 months

Due to Carcinoma of Recto Sigmoid several years

Due to Generalized Carcinomatosis

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 46 d
Of autopsy no

Duration

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 John T Skinner (M. D. or other) MD
Address 1402 Bryant Bldg Date signed 12/28/44

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....Charles M Quirk

Licensed Embalmer No.....3774

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.**