

FILED FEB 14 1945  
199  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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

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: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hours (Specify whether  
In this community 31 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. 3441 Benton Blvd. 8  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country U

3. (a) PRINT FULL NAME MRS. CHARLOTTE C. MYERS

3. (b) If veteran, name war XX

3. (c) Social Security No. 486-01-5997

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2nd  
year 1945 hour 5: minute 45 A. M.

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married. 3 divorced Divorced

6. (b) Name of husband or wife Scott Myers 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased: February 19 1891  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-30, 1945 to 2-7, 1945  
that I last saw her alive on 2-1-, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 53 Months 11 Days 13 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Intestinal obstruction 2 days

Due to \_\_\_\_\_

9. Birthplace: Easton Kansas  
(City, town, or county) (State or foreign country)

Due to Ovarian cyst not B.

10. Usual occupation Claim Auditor

Other conditions Coronary sclerosis  
(Include pregnancy within 3 months of death)

11. Industry or business Nat'l Protective Ins. Co.

MOTHER FATHER { 12. Name Robert McClure

13. Birthplace No Record U

14. Maiden name Amanda Helsey U  
(City, town, or county) (State or foreign country)

15. Birthplace Princeton Missouri U  
(City, town, or county) (State or foreign country)

Major findings: Of operations Ovarian cyst

Of autopsy Coronary sclerosis

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

16. (a) Informant Scott Myers

(b) Address 20 West 36th St.

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 2-5-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director J. M. Wagner  
Kansas City, Mo.

(b) Address \_\_\_\_\_

19. (a) 2-3-45 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

23. Signature J. M. Wagner  
Address KC Mo Date signed 2-2-45

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**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 Alvin R. Gauschfeld

Licensed Embalmer No. 4159

P. O. Address Kansas City 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.**