

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: **Trinity Lutheran Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Weeks** (Specify whether years, months or days)
In this community **50 years**

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. **4520 Genesee** (If rural, give location)
(e) Citizen of foreign country? **unknown** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM H MEYERS

(b) If veteran, name war **No** (c) Social Security No. **499-14--1970**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Minnie Meyers** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Oct 26 1864**
(Month) (Day) (Year)

8. AGE: Years **82** Months **1** Days **5** If less than one day hr. min.

9. Birthplace **No record** (City, town, or county) (State or foreign country)

10. Usual occupation **Box Maker**

11. Industry or business _____

12. Name **George Meyers**

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

14. Maiden name **No record**

15. Birthplace **No record** (City, town, or county) (State or foreign country)

16. (a) Informant **William Meyers**

(b) Address **4334 Bell**

17. (a) **Burial** (b) Date thereof **12/2/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **Dwight and John**

(b) Address **20 West Linwood**

19. (a) **12-2-46** (b) **Geraldine Holman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **1** year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him **alive on** **Pathologist** _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **acute cardiac dilatation** Duration _____

Due to **acute pancreatitis, hepatic cirrhosis and nephritis (hepato-renal syndrome)**

Due to **Peritonitis due to perforation of Cecum (in m.o.)**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations **1250**

Of autopsy **above**

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? _____

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

23. Signature **Jaded Hill** (M. D. or other) **20**
Address **Trinity Lutheran Hosp.** Date **2 Dec 46**

MOTHER FATHER

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

John Conway

Licensed Embalmer No.....

4424

P. O. Address.....

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

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