

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18165**
2293

22/28
MAY 21 1953

REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Hickman Mills	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lakeside Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Infant LESTER b. (Middle) L. c. (Last) Meyer		4. DATE OF DEATH (Month) (Day) (Year) 4 28 53	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH 4-28 -53	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo. D		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Robert Meyer		13b. MOTHER'S MAIDEN NAME Barbara Bowling	
14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Robt. Meyer		ADDRESS Hickman Mills, Mo. RR#3	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Atelectosis		INTERVAL BETWEEN ONSET AND DEATH At Birth	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		ANTECEDENT CAUSES DUE TO (b) Prematurity DUE TO (c)		76 ²⁵	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4-28, 1953, to 4-28, 1953, that I last saw the deceased alive on 4-28, 1953, and that death occurred at 9:40A m., from the causes and on the date stated above.

23a. SIGNATURE <i>Chas. G. Stephens</i>		23b. ADDRESS 3 E. 39 Th. St. KCMO.		23c. DATE SIGNED 4-29-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-2-53		24c. NAME OF CEMETERY OR CREMATORY Floral Hills	
24d. LOCATION (City, town, or county) (State) Kansas City Mo					

DATE REC'D BY LOCAL REG. 5-2-53		REGISTRAR'S SIGNATURE <i>Geraldine Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar	
				ADDRESS KCMO.	

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....
P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.