

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29919

State File No. \_\_\_\_\_

*James*  
FILED SEP 22 1955

BIRTH NO. _____		REG. DIST. NO. <u>146</u>		PRIMARY REG. DIST. NO. <u>5568</u>		Registrar's No. <u>344</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY OR TOWN <u>Kansas City 29</u>		c. LENGTH OF STAY (in this place) <u>14 yrs</u>		c. CITY OR TOWN <u>Kansas City 29</u>		Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4302 Carlisle</u>				STREET ADDRESS (If rural, give location) <u>4302 Carlisle 300 1/2</u>			
3. NAME OF DECEASED (Type or Print) <u>LOTTIE</u>		a. (First)		b. (Middle) <u>C.</u>		c. (Last) <u>MYERS</u>	
4. DATE OF DEATH <u>Sept. 11, 1955</u>		(Month)		(Day)		(Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb 27, 1880</u>	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Atchison, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William Albrie</u>		13b. MOTHER'S MAIDEN NAME <u>Blanchette West</u>		14. NAME OF HUSBAND OR WIFE <u>James F. Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>James F. Myers</u>		ADDRESS <u>4302 Carlisle</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES				?	
		DUE TO (b) <u>Hypertension</u>				?	
		DUE TO (c) <u>arteriosclerosis 331X</u>				?	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		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 <u>19 Feb</u> , 19 <u>55</u> , to <u>11 Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 Sept</u> , 19 <u>55</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>H. A. Anderson MD</u> (Degree or title) _____				23b. ADDRESS <u>Independence</u>		23c. DATE SIGNED <u>9-13-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 14, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Buckner Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Buckner, Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-14-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>354</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Independence, Mo.</u>			

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.....  
*Dillon L. Teague*

Licensed Embalmer No. 422

P. O. Address *Indep 7*

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.