

FILED JUN 1 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **43548**

| | | | | | | | |
|---|---|---|---|---|---|--|---|
| BIRTH NO. _____ | | REG. DIST. NO. 314 | | PRIMARY REG. DIST. NO. 6064 | | Registrar's No. 35 | |
| 1. PLACE OF DEATH a. COUNTY St. Clair | | | | 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 town or township) Rural- Osceola | | c. LENGTH OF STAY (in this place) 1 day | | c. CITY OR TOWN Kansas City | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 9-1-8 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Osceola Township | | | | e. STREET ADDRESS (If rural, give location) 6625 East 13th; K.C., Mo; | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Sie b. (Middle) -- c. (Last) Myers Jr. | | | 4. DATE OF DEATH (Month) (Day) (Year) June 4, 1955 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 19, 1935 | | 9. AGE (In years last birthday) 20 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lathe Operator | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Gerster Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Sie Myers | | 13b. MOTHER'S MAIDEN NAME Katie Hicks | | 14. NAME OF HUSBAND OR WIFE Shirely Myers | | | |
| 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. 497-38-2414 | | 17. INFORMANT'S SIGNATURE OR NAME Sie Myers Gerster Missouri ADDRESS _____ | | | |
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowned | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | |
| | 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 checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sac River | | 21c. (CITY, TOWN, OR TOWNSHIP) 42 (COUNTY) Osceola Twp; (STATE) St. Clair Missouri | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6-4-55 1: P.M. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Boat Capsized | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1: P. m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) James B. Paulsen Coroner of Osceola | | | | 23b. ADDRESS Yes | | 23c. DATE SIGNED 5/26/56 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 6-7-55 | 24c. NAME OF CEMETERY OR CREMATORY Bucher | | 24d. LOCATION (City, town, or county) (State) Gerster Missouri | | |
| DATE REC'D BY LOCAL REG. 5/26/56 | | REGISTRAR'S SIGNATURE Ruth Seewer | | 25. GENERAL DIRECTOR'S SIGNATURE Harold Eugene Deane ADDRESS _____ | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

10. 300

10. 48

100

JUN 1 1968

REC 16 1968

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 *J.B. [Signature]*

Licensed Embalmer No. *303*

P. O. Address *[Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.