

THE DEPARTMENT OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

340

FILED JAN 14 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp. Length of stay in lb 6 days		d. STREET ADDRESS (If outside, give location) 1518 S. 11th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WALTER Middle L. Last MYERS			4. DATE OF DEATH Month Jan. Day 3, Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1881	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. employee		10b. KIND OF BUSINESS OR INDUSTRY Railroad Co.	11. BIRTHPLACE (City and state or country) Nodaway County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Myers			14. MOTHER'S MAIDEN NAME Celila Miller			
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. 495-09-6367	17. INFORMANT Address Mrs. W. L. Myers, 1518 S. 11th, St. Joseph, Mo.			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident			INTERVAL BETWEEN ONSET AND DEATH Days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension and calcareous vessels			DUE TO (c) Diabetes mellitus		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, obesity			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE	
21. I attended the deceased from Dec 27, 1956 to Jan 3, 1957 and last saw him him alive on Jan 3, 1957 . Death occurred at 5:22p. m on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) W. L. Myers, M.D.			22b. ADDRESS 702 Edmund St City		22c. DATE SIGNED 1-5-57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1/4/1957	23c. NAME OF CEMETERY OR CREMATORY Hopkins, Missouri		23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR ADDRESS Heston-Bowman St Joseph Mo		25. DATE RECD. BY LOCAL REG. Jan. 9, 1957	26. REGISTRAR'S SIGNATURE Coehen M. Allison	
---	--	---	---	--

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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 *Clayton Wood*
Licensed Embalmer No. *380*

P. O. Address *748 12th St*

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.