

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

36162

4466

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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|---|--|--|--|
| 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, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3020 Forest | | Length of stay in lb 33 yrs | d. STREET ADDRESS (If outside, give location) 3020 Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First HELEN Middle L. Last STEPHENS | | | 4. DATE OF DEATH Month Sept. Day 25 Year 1957 | | | |
| 5. SEX Female | 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 May 29, 1903 | 9. AGE (In years last birthday) 54 | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr of Apt House | | 10b. KIND OF BUSINESS OR INDUSTRY Forest Apts | 11. BIRTHPLACE (City and state or country) Marshall, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME W. M. Layer | | | 14. MOTHER'S MAIDEN NAME Josephine Roberts | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) AID | | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT Address F. R. Stephens, 3020 Forest. | | | |

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|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Pnem | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ca of Breast & generalized metastases - lungs, liver, et | | |
| DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | |
|---|--|---|
| 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 11:00 a. m. / Month Sept Day 24 Year 1957 | | |
| 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 COUNTY STATE |

21. I attended the deceased from **1954** to **24 Sept 57** and last saw her alive on **24 Sept 57**
Death occurred at **m** on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|---|---|---------------------------------------|
| 22a. SIGNATURE (Degree or title) Robert M. Myers M.D. | 22b. ADDRESS 1025 North Bluff | 22c. DATE SIGNED 25 Sept 57 |
|---|---|---------------------------------------|

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|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial & Re- moval | 23b. DATE 7-28-1957 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery | 23d. LOCATION (City, town, or county) (State) Sedalia, Missouri |
|--|-------------------------------|--|---|

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|--|---------------------------|--|---|
| 24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home | ADDRESS 9-25-57 | 25. DATE RECD. BY LOCAL REG. 9-25-57 | 26. REGISTRAR'S SIGNATURE Neva Minshall |
|--|---------------------------|--|---|

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

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
Robert M. Myers



L. R. M. Meyer
Rialto Bldg.
No 2-4751

12-4 Per

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 *Jamie W. Wain*

Licensed Embalmer No. *469*

P. O. Address *Kansas City*

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.