

pt. Health,  
, & Welfare  
S. Public  
lth Service

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44516  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5703

S. 300  
ev. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>_____</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		Length of stay in lb <b>22 days</b>	d. STREET ADDRESS <b>3745 Lindall Blvd</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES THEODORE MYERS</b>			4. DATE OF DEATH <b>11th 30th 1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>3</b> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-11-93</b>	9. AGE (In years last birthday) <b>64 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	11. BIRTHPLACE (City and state or country) <b>Ft Wayne, Ind</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Lee G. Myers</b>		13b. MOTHER'S MAIDEN NAME <b>Lucetta Keener</b>		14. NAME OF HUSBAND OR WIFE <b>_____</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>494 16 9710</b>	17. INFORMANT Address <b>V.A. Hospital, K.C., Mo. Julia Jordan, St. Louis, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, right lung</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>_____</b>					<b>162x</b>
DUE TO (c) <b>Bronchogenic Carcinoma, Right lower lobe</b>					
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 checked="" type="checkbox"/> NO <input 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.) <b>_____</b>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>_____</b>			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>_____</b>		20f. CITY, TOWN, OR LOCATION <b>_____</b>		COUNTY <b>_____</b>	STATE <b>_____</b>
21. I attended the deceased from <b>November 8, 1957</b> to <b>November 30, 1957</b> and witnessed the death. Death occurred at <b>6:50 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>E. Foroughi</b> (Degree or title) <b>MD</b>			22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>		22c. DATE SIGNED <b>11-30-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>DEC. 2. 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>_____</b>		23d. LOCATION (City, town, or county) (State) <b>WILLARD Ohio</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS, KANSAS CITY, MO.</b> ADDRESS <b>351 BRUSH CREEK</b>		25. DATE RECD. BY LOCAL REG. <b>12-1-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

112

1 FEB 25 1958

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 Chester K Brown

Licensed Embalmer No. 4931  
P. O. Address K E MO

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.