Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004604
STATE FILE NUMBER

FILED MAR 16 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 257

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN St. Joseph — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Missouri Methodist Hospital — Length of stay in 1b 30 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph 0117 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) Rt. 8, Walter L. Street — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Nellie Middle Adelle Last Myer
4. DATE OF DEATH Month March Day 6 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH Aug. 16, 1882
9. AGE (In years last birthday) 76 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (City and state or country) Doniphan County
12. CITIZEN OF WHAT COUNTRY? Kansas
13a. FATHER'S NAME George O. Morehead
13b. MOTHER'S MAIDEN NAME Della K. Brown
14. NAME OF HUSBAND OR WIFE George F. Myer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT Address Mrs. Minnie French, McCook Nebraska

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) gastroenteritis — 5 days
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Senility due to Generalized Arteriosclerosis 5711
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 9/5/55, to 3/6/59 and last saw her alive on 3/6/59
Death occurred at 6:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Martin H Christ MD (Degree or title)
22b. ADDRESS 6106 Kingshill Ave
22c. DATE SIGNED Mar 2, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE March 9, 59
23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery
23d. LOCATION (City, town, or county) (State) Highland, Kansas

24. FUNERAL DIRECTOR ADDRESS Clark Funeral Home St. Joseph, Mo.
25. DATE RECD. BY LOCAL REG. Mar. 13 1959
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Martin H. Christ

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 Earl A. Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph

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.