

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032710

FILED VS. OCT. 13 1959 50

Primary Registration District No. 4239 Registrar's No. 219

STATE FILE NUMBER

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 Lee's Summit		Length of stay in 1b 15 yrs.		c. CITY OR TOWN Lee's Summit		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 413 So. Main			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 413 So. Main			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charley Middle A. Last Myers				4. DATE OF DEATH Month Oct. Day 4, Year 1959			
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 July 1, 1906	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop		11. BIRTHPLACE (City and state or country) Sayracuse, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME James W. Myers			13b. MOTHER'S MAIDEN NAME Ella Ree Rice			14. NAME OF HUSBAND OR WIFE Bessie 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. 491-24-2670		17. INFORMANT Address Bessie Myers, Lee's Summit, 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) Acute Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 10 Mins.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Dis.						8 Mos.	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Duodenal Ulcer						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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: _____ a.m. _____ p.m. _____	Month, Day, Year						
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 10-1-1958 , to 10-4-59 and last saw ^{her} him alive on 10-4-59 Death occurred at 9 30 P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) M.D. Durrell M.D.				22b. ADDRESS 188. 3rd St. Lee's Summit, Mo.		22c. DATE SIGNED 10/5/59.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 7, 1959	23c. NAME OF CEMETERY OR CREMATORY Sayracuse Cemetery		23d. LOCATION (City, town, or county) (State) Sayracuse, Missouri			
24. FUNERAL DIRECTOR Langsford Funeral Home, Lee's Summit			ADDRESS Mo.	25. DATE RECD. BY LOCAL REG. 10-6-1959	26. REGISTRAR'S SIGNATURE D. B. Langsford		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 23 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed D B Longford

Licensed Embalmer No. 496

P. O. Address Leisum

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.