

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042176

FILED VS NOV 17 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5480

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 4 days		c. CITY OR TOWN Shawnee		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 12416 West 61st		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Boyd Middle Myers Last Myers				4. DATE OF DEATH Month 10 - Day 30 - Year 60				
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 9-26-05	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MRT Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Parsons, Kans		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Fred Myers			13b. MOTHER'S MAIDEN NAME Sarah Fritter		14. NAME OF HUSBAND OR WIFE Elizabeth Myers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Elizabeth Myers Shawnee Address 12416 W 61st				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) traumatic hemorrhage / brain lacer							
	DUE TO multiple rib fracture, fracture / sternum							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 checked="" 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.) one car accident					
20c. TIME OF INJURY Hour 6:30 Month 10 Day 22 Year 60		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 7th Street		20f. CITY, TOWN, OR LOCATION Clanville		COUNTY Johnson STATE Kans
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ 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) Dr. R. Keally, Sr. Dept. coroner				22b. ADDRESS 6622 Park of Shawnee		22c. DATE SIGNED 10-31-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov 2, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) Kansas City		23e. STATE Kans		
24. FUNERAL DIRECTOR Muehlebach		ADDRESS 6800 Troost		25. DATE RECD. BY LOCAL REG. 10-31-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer		

DOCUMENT

BY AFFIDAVIT OF GEO. C. KEATON, JR., M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address 91 E. 7th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.