

UG 23 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space
M. C. [Signature]
23542

1. PLACE OF BIRTH

County *Greene* Registration District No. *318*
Township *Springfield no* Primary Registration District No. *2091*
City *Springfield* (No. *2091*) St. *Springfield* Ward)

File No. *23542*
Registered No. *517*

2. FULL NAME *Mrs Jesse B Myers*

(a) Residence. No. *455 E. Market* Ward. *Springfield*
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Friday July 13 1928*
17. I HEREBY CERTIFY, That I attended deceased from *Feb 1* 19 *28* to *July 13* 19 *28*

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF *M. L. Myers 1856*

that I last saw him *alive on July 13 1928*, and that death occurred, on the date stated above, at *7:15 p.m.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *August 7 - 1856*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina pectoris

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min.
71 YEARS *10* MONTHS *14* DAY

CONTRIBUTORY (SECONDARY) *None* (duration) yrs. mos. da.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? *No* DATE OF
WAS THERE AN AUTOPSY? *No*

9. BIRTHPLACE (CITY OR TOWN) *Ohio*
(STATE OR COUNTRY)

10. NAME OF FATHER *Jesse M. Patterson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Ohio*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mary Patterson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Ohio*
(STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS *Urinary symptoms of Angina* M. D. *[Signature]*
(Signed) (Address) *721 Woodruff St*

14. INFORMANT *Frank Chamberlain*
(Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Maple Park* DATE OF BURIAL *July 19 28*
SPRINGFIELD, MO.

15. FILE *7-1528* *Oct Forest Hill* REGISTRAR

20. UNBERTAKER *W. H. [Signature]* ADDRESS *SPRINGFIELD, MO.*

1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

6

100

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Greene

Registration District No. 318

File No.

Township

Primary Registration District No. 2001

Registered No. 317

City Springfield (No.)

St.

Ward)

2. FULL NAME

Mrs. Jesse B Myers

(a) Residence. No. St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED 7-15-28 1928

Oct Forst M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1928

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19....., and that

that I last saw h..... alive on, 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

July 15, 1928

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-23542