

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

Do not use this space. *Long*
26794

1. PLACE OF DEATH
County *Vermon* Registration District No. *875*
Township *11* Primary Registration District No. *6162*
City *Vermon* (No. *1*) St. *Vermon* Ward *1*

2. FULL NAME *Wm S. Meyers*
(a) Residence No. *State Hospital #3* St. *Vermon* Ward *1*
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *7* yrs. *22* mos. *22* ds. How long in U.S., if of foreign birth? *7* yrs. *22* mos. *22* ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar. 29 / 60*

7. AGE YEARS MONTHS DAYS *69 3 26* (If LESS than 1 day, *hrs.* or *mins.*)

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

9. BIRTHPLACE (CITY OR TOWN) *Davenport* (STATE OR COUNTRY) *Ia.*

10. NAME OF FATHER *R.D. Meyers*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *not known* (STATE OR COUNTRY) *not known*

12. MAIDEN NAME OF MOTHER *Madine Huffman*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *not known* (STATE OR COUNTRY) *not known*

14. INFORMANT *Mrs J.M. Smith* (Address) *820 Longwood Ave Des Moines*

15. FILED *8-6-29* *O.R. King* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 24 19 29*

17. *I* HEREBY CERTIFY, That I attended deceased from *Dec 2*, 19*28*, to *July 24*, 19*29* that I last saw him alive on *July 24*, 19*29*, and that death occurred, on the date stated above, at *8 P M*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis
930
97 (duration) *?* yrs. *?* mos. *?* ds.

CONTRIBUTORY (SECONDARY) *Chronic myo-carditis* (duration) *?* yrs. *?* mos. *?* ds.

18. WHERE WAS DISEASE CONTRACTED *908 B* IF NOT IN PLACE OF BIRTH

19. DID AN OPERATION PRECEDE DEATH? *no.* DATE OF *no.*

20. WAS THERE AN AUTOPSY? *no.*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical* (Signed) *T T O'Neil* M.D.

*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 *Davenport Iowa* DATE OF BURIAL *7/26/29*

20. UNDERTAKER *Longwood Home Nevada* ADDRESS *Nevada*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. *1929* *108* *257* *2* *31*

