

Duplicate of 44958-39

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

20073
Do not use this space.

1. PLACE OF DEATH
 (a) County WAYNE Registration District No. 890
 (b) Township St. Francis Primary Registration District No. 6188, 39
 (c) City GRAVELTON - Mo (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME B20 GROVER M. MYERS
 (a) Residence, No. GRAVELTON Mo St. 429 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 1-1884

7. AGE	YEARS	MONTHS	DAYS	If LESS than day, or
	<u>54</u>	<u>5</u>	<u>14</u>	<u>hrs</u> <u>min</u>

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Carpenter
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (yrs. mos. ds.) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co. Mo.

FATHER
 13. NAME M. M. Myers
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Davidson Co. N. Carolina

MOTHER
 15. MAIDEN NAME Elgie C. Binley
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Heppner Co. Mo.

17. INFORMANT (ADDRESS) Dr. O. H. Myers
Shenandoah Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Shenandoah Mo. DATE Apr. 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Cray F. Home
Shenandoah Mo.

20. FILED April 16, 1939 Mabel Beasley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 10, 1939 to April 15, 1939
 I first saw him alive on April 14, 1939 Death is said to have occurred on the date stated above, at 3 P. m.
 The principal cause of death and related causes of importance were as follows:
Lobar pneumonia
Bilateral.
 Date of onset 4-8-39

Other contributory causes of importance:
Influenza

Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. F. Wagner, M. D.
 (Address) Shenandoah, Mo.

K. E.—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.

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.....

Body Not Embalmed Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.