

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42588

Registration District No. 4

Primary Registration District No. 3001

Registrar's No. 305

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Wishville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Green-Smith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Five days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Clarence Myers

8. (b) If veteran, name war L 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Belle 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Febr 18 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 10 11 hr. min.

9. Birthplace Green Castle Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Ananias Myers

18. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Georgia Ann Carlston

15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Belle Myers

(b) Address Green City, Mo.

17. (a) Perine (b) Date thereof Dec 31 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wilmington

18. (a) Signature of funeral director C. Schaefer

(b) Address Wishville, Mo.

19. (a) Jan. 3/40 (b) Spencer L. Inman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
(c) City or town Green City, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route 1
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29th
year 1939 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from 12-28
1939, to 12-29, 1939.

that I last saw him alive on 12-29, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death Pericarditis Duration 2 days
Septicemia, liver, lung & kidney abscesses 1 week
Due to Streptococcus sore throat 2 weeks

Due to _____

Other conditions (include pregnancy within 3 months of death) 116

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. King M.D. (M. D. or other) !

Address Wishville Date signed 12-29-39

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.

RECEIVED

District Health Officer No. 10

District File Number 1-40-89

Date Filed JAN 8 1940

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Frank D. Schoen

Licensed Embalmer No. 2016

P. O. Address Milan, Mo.

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.