

Registration District No. 117Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County. JASPER 2
 (b) City or town. JOPLIN
 (c) Name of hospital or institution: 511 S. COX
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. NO (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME WILLIAM EDWARD MYERS.3. (b) If veteran, name war. NO 3. (c) Social Security No. NO4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE6. (b) Name of husband or wife NO 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased MAR. 9, 1937.
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
2 9 25 hr. min.9. Birthplace JOPLIN MO:
(City, town, or county) (State or foreign country)10. Usual occupation NO

11. Industry or business

12. Name NATHAN MYERS:13. Birthplace SENECA MO
(City, town, or county) (State or foreign country)14. Maiden name May Orsine15. Birthplace SENECA MO:
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Nathan Myers(b) Address 511 S. COX AVE JOPLIN MO17. (a) BURIAL (b) Date thereof 1-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Seneca Cemetery18. (a) Signature of funeral director HURLBUT UND. CO.(b) Address JOPLIN MO. 37119. (a) 1-5-40 (b) W D James
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI: (b) County. JASPER
 (c) City or town. JOPLIN
 (If outside city or town limits, write "RURAL")
 (d) Street No. 511 S. COX.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? NO years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN 3, 1940:
year _____ hour _____ minute 2-55 PM21. I hereby certify that I attended the deceased from Jan 2-1940
Jan 2, 1940, to Jan 3, 1940
that I last saw him alive on Jan 3, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Asphyxiation
Paralytic
Duration 1-1-40
3 daysDue to _____
Due to 10
Other conditions (Include pregnancy within 3 months of death)Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically22. 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) _____
(a) Means of injury _____
23. Signature H. Walker (M. D. or other) MD
Address Joplin Date signed 1-4-40

RECEIVED

District Health Officer No. 6,

District File Number 240-539

Date Filed FEB 15 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.....

Licensed Embalmer No. 4099

P. O. Address Joplin 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.