DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8420

Registration District No. 803 FILED MAR 11 1940

Primary Registration District No. 61-3-7 95-2

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Houston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) 670

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas

(c) City or town Houston
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Charles R. Myres

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary E. Myres

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased October (Month) 28 (Day) 1863 (Year)

8. AGE: Years 76 | Months 3 | Days 20 | If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Ill. (State or foreign country) 1

10. Usual occupation 9

11. Industry or business Cafe 7

FATHER
12. Name ✓ 9
13. Birthplace _____ (City, town, or county) ✓ (State or foreign country) 7

MOTHER
14. Maiden name ✓
15. Birthplace _____ (City, town, or county) ✓ (State or foreign country)

16. (a) Informant's own signature Mary E. Myres
(b) Address Houston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Houston cemetery

18. (a) Signature of funeral director Gaylord V. Elliott
(b) Address Houston Mo. 911

19. (a) Feb. 20 1940 (Date received local registrar) (b) Mabel Shacklett (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 18
year 1940 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from JUNE, 1938, to FEB 18, 1940;
that I last saw him alive on FEB 18, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
CORONARY THROMBOSIS	2 WTS
Due to DEGENERATIVE CARDIO VASCULAR DISEASE	
Due to SENILITY	
Other conditions (Include pregnancy within 3 months of death)	

95 B

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

23. Signature L. M. Dillman (M.D. or other) MD
Address Houston Date signed 2-20-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 I X19511

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.

RECEIVED
District Health Officer No. 5,
District File Number 340278
Date Filed 3-8-40

Signed Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, 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.

No. 2B
-2-21-40
1 X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8420

Registration District No. 863 Primary Registration District No. 4522 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Houston (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Charles R. Meyers

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 20 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Unknown

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Feb 20 1940 (Date received local registrar) (b) Mabel Shackleton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 18 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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 statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature L. M. Dilman (M. D. or other)

Address Houston Date signed