V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10220

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 300

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2027 Jones (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 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph (If outside city or town limits write "RURAL")
(d) Street No. 2027 Jones (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME EDMOND V. MYERS 620

3. (b) If veteran, name war none — 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Martha Myers — 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Jan. (Month) 26th. (Day) 1855 (Year)

8. AGE: Years 85 — Months 1 — Days 27 — If less than one day ____ hr. ____ min.

9. Birthplace Unknown (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation Florist

11. Industry or business Myers Watson Floral Co.

FATHER
12. Name Emanuel Myers
13. Birthplace unknown (City, town, or county) England (State or foreign country) 4

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) unknown (State or foreign country) 1

16. (a) Informant Myers Watson
(b) Address 2027 Jones St. Joseph, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Mar. 15th. 40 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director FLEEMAN & SON, INC.
(b) Address 1946 Calhoun St. Joseph, Mo.

19. (a) March 14, 1940 (Date received local registrar) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 13th. year 1940 hour 3 minute 45 A M.

21. I hereby certify that I attended the deceased from Aug 1-1939, 19__, to Mar 13th, 1940 that I last saw him alive on Mar 13-40, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Auricular Fibrillation — Duration Aug 1-39

Due to ____

Due to ____ 95a

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

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) no
(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)
85 While at work? — (e) Means of injury —

23. Signature H. W. Kearby MD (M. D. or other) 1
Address St Joseph Mo Date signed 3-14-40

(Licensed Embalmer's Statement on Reverse Side)

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 C G Swan

Licensed Embalmer No. H 0 82

P. O. Address St Joseph

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.