

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35470

State File No. \_\_\_\_\_

Registration District No. 384

Primary Registration District No. 583

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town West Plains, Mo. Howell Twp  
(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 2  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell  
(c) City or town Howell Twp  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 11  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from September 2, 1940, to Sept. 11, 1940,  
that I last saw him alive on Sept. 11, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 10 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Senility  
(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?  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature P. D. Gurn (M. D. or other) 1  
Address West Plains, Mo Date signed 9-19-40

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

3. (a) PRINT FULL NAME Mrs. Emily Myers

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Richard Montgomery Myers 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Dec. 18 1874  
(Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Nathan Aldridge, Sr.

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

14. Maiden name Jane Martin

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

16. (a) Informant R. M. Myers

(b) Address West Plains, Mo

17. (a) Burial (b) Date thereof 9-13-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Howell Valley

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo 344

19. (a) 10-1-40 (b) Vida W. SIMONS  
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 5,

District File Number. 10401095

Date Filed .....

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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 Raymond A. Roberts

Licensed Embalmer No. 3435

P. O. Address West Plains, 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.**