

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43070**

JAN 20 1940
Registration District No. _____

Primary Registration District No. **480-565** Registrar's No. **9**

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

1. PLACE OF DEATH:
 (a) County: Lincoln
 (b) City or town: Rural, Union
(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 _____
 In this community: all his life (Specify whether years, months or days) 21

8. (a) PRINT FULL NAME: Samuel A. Myers
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex: male 5. Color or race: white 6. (a) Single, widowed, married, divorced: married
 6. (b) Name of husband or wife: Elizabeth Mywes 6. (c) Age of husband or wife if alive: 67 years
 7. Birth date of deceased: Feb. 21, 1867
(Month) (Day) (Year)

8. AGE: Years: 72 Months: 9 Days: 12 If less than one day: _____ hr. _____ min.

9. Birthplace: Pike Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: _____

MOTHER FATHER
 12. Name: Wm. Myers
 13. Birthplace: Pa.
(City, town, or county) (State or foreign country)
 14. Maiden name: Sarah Emerson
 15. Birthplace: Pike Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant: Elizabeth Myers
 (b) Address: Briscoe, Mo.

17. (a) Burial (b) Date thereof: 12/5/1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: Sulphur Lick Cemetery

18. (a) Signature of funeral director: W.R. Vomund
 (b) Address: Silex, Mo.

19. (a) 12-8-1940 (b) O. H. Dameron
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Mo. (b) County: Lincoln
 (c) City or town: Rural
(If outside city or town limits, write "RURAL")
 (d) Street No.: 2 mi. south, Arbarn, Mo.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: December day: 3
 year: 1940 hour: 10 minute: 00 A. M.

21. I hereby certify that I attended the deceased from 11/27 1940, to 12/3 1940
 that I last saw him alive on 12/2 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
 Duration: 5 days

Due to: _____
 Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations: _____
 Of autopsy: _____
 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: J. S. Hoeger (M. D. or other) M.D.
 Address: W. H. Hiteford - Mo Date signed: 12-3-1940

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 me
#7, Registered Apprentice No. 7r
working under my personal supervision.

Signed W. P. Downing

Licensed Embalmer No. 2251

P. O. Address Self Inc.

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.