

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.

Registration District No. **284**

Primary Registration District No. **5403 4168**

Registrar's No. **10**

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Clarkton, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Clarkton, Mo
(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 MYRON Thomas Myers

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 21, 1931
(Month) (Day) (Year)

8. AGE: Years 9 Months 9 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Isaac Myers

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

14. Maiden name Lucille Mc Micran

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

16. (a) Informant's own signature Myron A. Myers

(b) Address Clarkton, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 9, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation mt. Liberty

18. (a) Signature of funeral director Laurel Funeral Home

(b) Address Campbell, Missouri

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature) 258

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7 year 1941 hour 6:25 minute _____ P. M.

21. I hereby certify that I attended the deceased from 6-7, 1941, to 6-7, 1941
that I last saw h. _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral abscess Duration Small

Due to Blood Clot

Due to Injury to head - accidental 3-21-41

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 6-3-41

(c) Where did injury occur? School grounds (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at school

While at work play (Specify type of place) Wichita hotel (e) Means of injury by play mate

23. Signature J. B. Stemmy (M. D. or other) MD

Address Clarkton, Mo Date signed 6-9-41

REV. 8-17-33
U. S. G. P. 1 X1981

RECEIVED

District Health Officer No. 2,

District File Number 741-876

Date Filed 7/15/41

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.....

P. O. Address.....

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.

Registration District No. 284

Primary Registration District No. 4168

Registrar's No. 10

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Charleston
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Myron Thomas Myers

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 S

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	Months	Days	If less than one day
				hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

15. Birthplace (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) 6-9-41 (Date received local registrar) (b) J. B. Stearns (Registrar's signature)

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1941 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.

Immediate cause of death _____ Duration _____

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 _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

