No. 2
-9-4-41
-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 28 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31160

Registration District No. 576 Primary Registration District No. 4444 Registrar's No. 12

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Camden Twn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 15 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ray 89
(c) City or town Camden 0
(If outside city or town limits, write "RURAL")
(d) Street No. no
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Jacob Daniel Myers
3. (b) If veteran, name war no
3. (c) Social Security No. no

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna B. Myers
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 13 (Day) 1871 (Year)

8. AGE: Years 71 Months 3 Days 17 If less than one day hr. min.

9. Birthplace Carroll (City, town, or county) 2 (State or foreign country)
10. Usual occupation Camden
11. Industry or business Retired Farmer.
FATHER
12. Name Joseph J Myers.
13. Birthplace Dont Kno Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Jane Welday
15. Birthplace Dont Kno 1 (City, town, or county) (State or foreign country)
16. (a) Informant Lwann Wells
(b) Address Camden, Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Hardin Mo
18. (a) Signature of funeral director [illegible]
(b) Address Richmond Mo.
19. (a) Aug 29 1942 (Date received local registrar) (b) [illegible] (Registrar's signature)

1228

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29 year 1942 hour 9 30 minute A.M.
21. I hereby certify that I attended the deceased from 1-15-42, 19, to 8-29-42, 19; that I last saw him alive on 8-27-42, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pernicious Anaemia	5 yrs
Due to	
Due to	
Other conditions Arteriosclerosis (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 Thos T Cook (M. D. or other)
Address Richmondm Mo. Date signed 8-29-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 9-28-42

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. 2073

P. O. Address Richmond

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—8-21-41
X29788

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. 31160

Registration District No. 294 Primary Registration District No. 4444 Registrar's No. 12

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Camden
(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)

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

3. (a) PRINT FULL NAME Jacob Daniel 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 13 (Day) 1[illegible] (Year)

8. AGE: Years 71 Months 3 Days 1 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-30-41 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Dr. G. F. Simmons (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29
year 1942 hour minute M.

21. I hereby certify that I attended the deceased from
19 , 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)

(b) 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