

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 423

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Mary's  
(If not in hospital or institution, write street number or location) 2 days  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Judith Myerscough, Twin A

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, Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: February 14, 1944  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name Sylvester Myerscough  
13. Birthplace Roma Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Beatrice Adams  
15. Birthplace Oklohoma city, Oklohoma  
(City, town, or county) (State or foreign country)

16. (a) Informant Sylvester Myerscough  
(b) Address 7719 Murdock Ave.

17. (a) Burial (b) Date thereof Feb. 17, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Peter & Paul Cemetery

18. (a) Signature of funeral director John H. Galt, St. Louis  
(b) Address 2630 Gravois Ave.

19. (a) FEB 18 1944 (b) E. G. McGowan, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Shrewsbury  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. 7719 Murdock Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16  
year 44 hour 8,20 minute A M.

21. I hereby certify that I attended the deceased from Feb. 14  
1944, to Feb. 16 1944  
that I last saw her alive on Feb. 16 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature birth  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 159  
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 0  
23. Signature Ralph E. Gustafson (M. D. or member)  
Address Webster Grover, Mo. Date signed 2/17/44

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

96  
8  
3

**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.....

*Robert F. Gibson*

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

**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, fact should be so stated above.**