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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Dr. Hogeboon

State File No. 27403

FILED SEP 12 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 671

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

39
2
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**1. PLACE OF DEATH:**

(a) County Greene

(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John's Hosp. 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether

In this community 4 Days years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Taney 106

(c) City or town Rockaway Beach 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sallie B. Myers

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife E.B. Myers

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

7. Birth date of deceased March (Month) 7 (Day) 1862 (Year)

8. AGE: Years 83 Months 5 Days 17 If less than one day hr. min.

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

10. Usual occupation Resort Operator

11. Industry or business

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

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

16. (a) Informant Mrs. Melvin R. Brown

(b) Address Kansas City, Kansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/25/45 (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Kansas

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 8-25-45 (Date received local registrar) (b) Dr. W.E. Handley (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug. day 24 year 1945 hour 8 minute 45 p. M.

21. I hereby certify that I attended the deceased from 8-23-45, 19 , to 8/24, 1945; that I last saw her alive on 8/24, 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Mesenteric Thrombosis | 36 HRS |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations Mesenteric Thrombosis | |
| 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 Leonard Hogeboom (M. D. or other)

Address Springfield Mo. Date signed 8/25/45

984 (Licensed Embalmer's Statement on Reverse Side)

## 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. 2457

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, fact should be so stated above.**