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

State File No. _____

FILED APR 21 1947
Registration District No. _____

Primary Registration District No. 3038

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Linn

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

(c) Name of hospital or institution: M. H. Korney Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 years (Specify whether years, months or days)

In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58

(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL")

(d) Street No. 120 E. Canal St 2
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME LILLIE BELL MYERS

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1947 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 15, 1947, to April 7, 1947, that I last saw her alive on April 7, 1947, and that death occurred on the date and hour stated above.

4. Sex F 1 5. Color or race W 6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife John H. Myers 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased: June 23, 1972
(Month) (Day) (Year)

Immediate cause of death Chronic hepatitis Duration 4 yrs.

8. AGE: Years 74 Months 9 Days 15 If less than one day hr. _____ min. _____

9. Birthplace: Kennigan Mo 0
(City, town, or county) (State or foreign country)

Due to arteriosclerosis

Due to Senility

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name James M. Thrasher

13. Birthplace D.K. 0
(City, town, or county) (State or foreign country)

14. Maiden name Martha Pickrel

15. Birthplace D.K. 0
(City, town, or county) (State or foreign country)

Major findings: Of operations 3/10

Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Walter Myers

(b) Address 1108 So. 23rd Quincy, Mo

17. (a) Burial (b) Date thereof Apr - 9 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kennigan Mo Hill General Home

18. (a) Signature of funeral director Walter B. Erwin

(b) Address Brookfield Mo

19. (a) 4-9-47 (b) Walter B. Erwin
(Date received local registrar) (Registrar's signature)

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 John R. Rubin (M. D. or other) MD

Address Phoenicia, Mo Date signed 4-8-47

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DISTRICT HEALTH OFFICE
Cameron, Mo.

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

J. R. Blacklock

Licensed Embalmer No. *2246*

P. O. Address *Brookfield Mo*

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.