

FILED DEC 3 1947  
Registration District No. 47

Primary Registration District No. 5764

Registrar's No. 402

1. PLACE OF DEATH

(a) County CALLAWAY

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

(c) Name of hospital or institution: R.F.D. #1 FULTON,  
(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 MISSOURI (b) County CALLAWAY 14

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

(d) Street No. FULTON R.F.D.#1  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Reed Smith 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 Wid. 9

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

7. Birth date of deceased MAR. 11 1877  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13  
year 1947 hour 9 minute 30 p. M.

21. I hereby certify that I attended the deceased from Aug. 30 1947 to Nov. 13 1947,  
that I last saw h.l.m. alive on Nov. 12 1947,  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

70 8 4 hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of Throat Duration 1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation FARMER

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

12. Name J.H. MYERS

13. Birthplace OK MO 0  
(City, town, or county) (State or foreign country)

14. Maiden name MARY J. SHROUD

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant MRS ROBT. DYE

(b) Address FULTON, MO

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

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

(b) Date of occurrence \_\_\_\_\_

17. (a) BURIAL (b) Date thereof Nov. 15, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope

(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? \_\_\_\_\_

18. (a) Signature of funeral director Glenn Y. Maurin

(b) Address 722 Cant St. Fulton, Mo

19. (a) Nov. 15, 1947 (b) W. C. Morsink  
(Date received local certificate) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Lloyd E. Hutchins (M. D. or other) D.O.  
Address Fulton, Mo Date signed 11/12/1947

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

Date Filed DEC 2 1947  
District File Number

District Health Officer No. 9,

RECEIVED

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.....

*Theodore Skinner, Jr.*, Registered Apprentice No. *55*

working under my personal supervision.

Signed *Glen G. Manpin*

Licensed Embalmer No. *2725-*

P. O. Address *Fulton, 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.