

FILED MAR 25 1948
Registration District No. 1998

Primary Registration District No. 4310

Registrar's No. 95

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Bevier
(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 Mo (b) County Macon
(c) City or town Bevier
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 18
year 1948 hour 12 minutes 30 P. M.

21. I hereby certify that I attended the deceased from Feb. 14, 1948
1948 to Mar. 18, 1948
that I last saw her alive on Mar. 17, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of transverse
Colon & peritoneum
Due to _____

Duration

Other conditions: Chronic myocardial
(Include pregnancy within 3 months of death) 3 yrs.

Major findings: Hot
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 2
23. Signature: Dr. K. Weidlich (M. D. or other) MD
Address: Bevier, Mo Date signed 3/20/48

3. (a) PRINT FULL NAME BEULAH SYLVIA MYERS

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

4. Female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Leo Myers 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased: 4-9-1903
(Month) (Day) (Year)

8. AGE: Years 44 Months 10 Days 9 If less than one day - hr. - min.

9. Birthplace: St. Catherine Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: domestic

11. Industry or business _____

MOTHER FATHER

12. Name: ROBERT LINEBERRY

13. Birthplace: St. Catherine Mo
(City, town, or county) (State or foreign country)

14. Maiden name: MARY JANE BRISSE

15. Birthplace: Linn Co. Mo
(City, town, or county) (State or foreign country)

16. (a) Informant: Leo Myers
(b) Address: Bevier Mo

17. (a) Burial (b) Date thereof: 3-20-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Wynndotte Cem.

18. (a) Signature of funeral director: W. J. Edwards

(b) Address: Bevier Mo

19. (a) 3-20-48 (b) Josephine King
(Date received local registrar) (Registrar's signature)

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

RECEIVED
District Health Officer No. 12
District File Number 3-48-564
Date MAR 23 1948

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. S. Edwards*
Licensed Embalmer No. ~~3257~~ 1961
P. O. Address *Beverly, 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.