

No. 300  
-10-47  
5-17-39  
3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17207

State File No. \_\_\_\_\_

FILED JUN 7 1948

Registration District No. 272

Primary Registration District No. 4427

Registrar's No. 68

1. PLACE OF DEATH:

(a) County Pulaski

(b) City or town Waynesville

(c) Name of hospital or institution: DeWitt Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 1/2 hrs.

In this community 5 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski

(c) City or town Waynesville Rural

(d) Street No. \_\_\_\_\_

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Loran Stafford Myers

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2

year 1948 hour 2 minute 55 PM.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife No

6. (c) Age of husband or wife if alive No years

7. Birth date of deceased September 26, 1928

21. I hereby certify that I attended the deceased from June 2, 1948, to June 2, 1948

that I last saw him alive on June 2 and that death occurred on the date and hour stated above.

Immediate cause of death Open Skull Fracture (Cerebral Hemorrhage)

Duration \_\_\_\_\_

8. AGE:

Years	Months	Days	If less than one day
<u>10</u>	<u>7</u>	<u>5</u>	hr. _____ min. _____

Due to Fall from truck

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

9. Birthplace Zion Illinois

10. Usual occupation School Child

Other conditions \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

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

12. Name Stafford Myers

13. Birthplace Bowden North Dakota

14. Maiden name Evelyn Richardson

15. Birthplace Zion Illinois

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

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

(b) Date of occurrence 8-5

(c) Where did injury occur? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant Stafford Myers

(b) Address Arlington, Missouri

17. (a) removal (b) Date thereof 6/3/48

(c) Place: burial or cremation Zion, Ill

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

(c) Means of injury g

23. Signature R. O. DeWitt (M. D. or other) Da

Address Waynesville, Mo Date signed 6-2-48

18. (a) Signature of funeral director Walter J. Hedges

(b) Address Iberia, Missouri

19. (a) 6-3-48 (b) Shelma C. Buckthorpe

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

NO COPY  
MISSOURI DIVISION OF HEALTH  
REGISTERED

**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

*Walter P. Hedger*

Licensed Embalmer No. ....

4265

P. O. Address.....

Iberia, Missouri

**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.**

Registration District No. 290

Primary Registration District No. 4427

1. PLACE OF DEATH:

(a) County Pulaski

(b) City or town Waynesville

(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) County \_\_\_\_\_ State \_\_\_\_\_

(b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

3. (a) PRINT FULL NAME Loren S. Myers

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Sept 26 1921  
(Month) (Day) (Year)

8. AGE: Years 10 Months 7 Days \_\_\_\_\_ (Less than one day)

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

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

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1948 day \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ that I saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

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

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

PHYSICIAN

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

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

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) accident

(b) Date of occurrence June 2, 1948

(c) Where did injury occur? Highway (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway

While at work? \_\_\_\_\_ Means of injury Fall

23. Signature K.D. Stewart (M. D. or other) Do.

Address Waynesville, Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-17207