

U.S. No. 300
FORM-10-47
Rev. 5-17-39
I 3906

18520

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 27 1948

Registration District No. 272

Primary Registration District No. 4545

Registrar's No. 26

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

1. PLACE OF DEATH:

(a) County Webster

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

(c) Name of hospital or institution: Blinn Hospital
(If not in hospital or institution, write street number or location)

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

In this community life (Specify whether years, months or days)

3: (a) PRINT FULL NAME Kathryn Arlene Myers

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife x

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

7. Birth date of deceased May - 2 - 1948
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>no</u>	<u>no</u>	<u>no</u>	<u>14 hr. 30 min.</u>

9. Birthplace Marshfield, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business x

12. Name Vern Myers

13. Birthplace Webster Co., Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Houise England

15. Birthplace Phelps Co., Nebraska
(City, town, or county) (State or foreign country)

16. (a) Informant Vern Myers

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-'48
(Month) (Day) (Year)

(c) Place: burial or cremation Good Spring

18. (a) Signature of funeral director Jerry J. J. J.

(b) Address Marshfield, Mo.

19. (a) May 12 - 1948 (Date received local registrar)

(b) J. J. J. (Registrar's signature) 392

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster

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

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

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

If yes, name country x

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3
year 1948 hour 1 minute 30 p.m.

21. I hereby certify that I attended the deceased from 5/2, 1948, to 5/3, 1948;
that I last saw her alive on 5/3, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis

Due to Prematurity

Due to _____

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

Major findings: Of operations 159

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury 2

23. Signature J. J. J. (M. D. or other) D.C.

Address Marshfield, Mo. Date signed 5/11/48

RECEIVED
District Health Officer No. 6,
District File Number 548-626
Date Filed MAY 24 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 _____

Licensed Embalmer No. _____

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.