

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7477

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 298

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 6 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 323 E. Colorado Ave.		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph	
		d. STREET ADDRESS (If rural, give location) 323 E. Colorado Ave.	

3. NAME OF DECEASED (Type or Print) AMOS	a. (First)	b. (Middle) J.	c. (Last) MYER	4. DATE OF DEATH (Month) 3 (Day) 14 (Year) 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED, WIDOWED	8. DATE OF BIRTH 5-13-1867	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) DeKalb, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME George F. Myer	13b. MOTHER'S MAIDEN NAME Rachel Snyder	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Nellie Smith, 323 E. Colo., City.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Hemiplegia		
	ANTECEDENT CAUSES DUE TO (b) Cerebral hemorrhage Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from March 10, 1949, to March 10, 1949, that I last saw the deceased alive on March 10, 1949, and that death occurred at 6:42 P. m., from the causes and on the date stated above.

23a. SIGNATURE M. Jenkins M.D.	(Degree or title)	23b. ADDRESS 228 Illinois Ave. St. Joseph	23c. DATE SIGNED 3/15/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-16-1949	24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	24d. LOCATION (City, town, or county) (State) DeKalb, Missouri
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DATE REC'D BY LOCAL REG. Mar. 16, 1949	REGISTRAR'S SIGNATURE E. C. Jenkins	382	25. FUNERAL DIRECTOR'S SIGNATURE J. Joseph	ADDRESS
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(Licensed Embalmer's statement on Reverse Side)

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

FEB 24 1954

MAR 30 1949

MAR 25 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *St Joseph, 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.