

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26339**

FILED AUG 18 1949

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **2662**

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		d. STREET ADDRESS (If rural, give location) 225 E. Velma	

3. NAME OF DECEASED (Type or Print)	a. (First) Fred	b. (Middle) Alvin	c. (Last) Myers	4. DATE OF DEATH (Month) (Day) (Year) 8 8 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 8-5-1940 (48)	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months 0	IF UNDER 1 YEAR Days 3	IF UNDER 1 YEAR Hours 	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Chaffee, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Edward Myers	13b. MOTHER'S MAIDEN NAME Margaret Troste	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME EDWARD MYERS	ADDRESS 225 E. VELMA LEMAY
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polio Myelitis		MEDICAL CERTIFICATION LEMAY INTERVAL BETWEEN ONSET AND DEATH 3 Days 0803
	ANTECEDENT CAUSES Respiratory type		
	DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)	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 **8/5**, 19**49**, to **8/8**, 19**49**, that I last saw the deceased alive on **8/8**, 19**49**, and that death occurred at **6:00 AM.**, from the causes and on the date stated above.

23a. SIGNATURE W. O. Feunoy, M.D. (Degree or title)	23b. ADDRESS Box 209 Cape Girardeau Mo	23c. DATE SIGNED 8/9/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-9-1949	24c. NAME OF CEMETERY OR CREMATORY Blodgett Cemetery	24d. LOCATION (City, town, or county) (State) Blodgett, Missouri.
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DATE REC'D BY LOCAL REG 8-16-1949	REGISTRAR'S SIGNATURE C. C. Summers	44	25. FUNERAL DIRECTOR'S SIGNATURE J. M. Dunnelee	ADDRESS Charleston, Mo.
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED

8-17-49

District Health Officer No. 4

District File Number 849-1097

Date Filed

AUG 17 1949

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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.

Signed

J. M. Runnel

Signed Student Embalmer

Licensed Embalmer No. 4413

P. O. Charleston, Mo

in his OWN

(Failure to comply with

Note: The above MUST BE SIGNED BY THE above constitutes grounds for revocation of license.

If this body is not embalmed, fact should be stated.