

FILED APR 17 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13646  
State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 171 PRIMARY REG. DIST. NO. 4267 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY OR TOWN <u>Odessa</u>		c. CITY OR TOWN <u>Odessa</u>	
c. LENGTH OF STAY (in this place) <u>20 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>U</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Homer</u> c. (Last) <u>Myers</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 1950</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 6, 1866</u>	9. AGE (In years last birthday) <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>WM. F. Myers</u>	13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	14. NAME OF HUSBAND OR WIFE <u>Myrtle Myers</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Myrtle Myers</u> ADDRESS <u>Odessa, Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>		
	ANTECEDENT CAUSES 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. <u>Nephrosclerosis</u>		4222	

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 April 11, 1950, to April 9, 1950, that I last saw the deceased alive on April 9, 1950, and that death occurred at 12:05 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. F. Slaughter, D.O.</u>	23b. ADDRESS <u>Odessa, Mo.</u>	23c. DATE SIGNED <u>4-10-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Apr. 11, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Odessa, Mo.</u>
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DATE REC'D BY LOCAL REG <u>Apr. 11 '50</u>	REGISTRAR'S SIGNATURE <u>Leta D. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Husman-Sparks</u> ADDRESS <u>Odessa, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED APR 14  
District Health Officer No. 8,  
District File Number.....  
Date Filed 4-15-50.....

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

*LeRoy L. Husman*

Licensed Embalmer No. 75-41

P. O. Address Alton, 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.