

FILED SEP 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32318

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 321 PRIMARY REG. DIST. NO. 4479 Registrar's No. 29 (29)

0980
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Queen City Schuyler CO</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Schuyler</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Queen City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Queen City</u>	
c. LENGTH OF STAY (in this place) <u>7 yrs</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Home</u>			

3. NAME OF DECEASED (Type or Print) <u>Menifee Claude Myers</u>			4. DATE OF DEATH <u>Sept 22 1950</u>		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 14 1869</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Scotland Co. Mo.</u>	12. CITIZENRY OF WHAT COUNTRY <u>U.S.</u>
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13a. FATHER'S NAME <u>Joseph W. Myers</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Collins</u>	14. NAME OF HUSBAND OR WIFE <u>Florance Starbuck</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>NO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Benny Myers</u> ADDRESS <u>Queen City 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u>		<u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u>		<u>16 months</u>
DUE TO (c) <u>Arteriosclerosis</u>		<u>20 years</u>	
II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>		<u>20 years</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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) <u>331X</u>
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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 Sept 20, 1950, to Sept 22, 1950, that I last saw the deceased alive on Sept 22, 1950, and that death occurred at 3:05A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Edward M. Roberts M.D.</u> (Degree or title)	23b. ADDRESS <u>2 Queen City Mo.</u>	23c. DATE SIGNED <u>9/23/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>9/24-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Queen City Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Queen City MO</u>
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DATE REC'D BY LOCAL REG. <u>9/24/50</u>	REGISTRAR'S SIGNATURE <u>Miss. Ruppel</u>	35% FUNDING DIRECTOR'S SIGNATURE <u>Wm. A. West</u> ADDRESS <u>Queen City MO</u>
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Date Received: SEP 27 1950
DISTRICT HEALTH OFFICE #2
District File Number 9-50-15
Date Filed: SEP 27 1950

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 _____

Wm A West

Licensed Embalmer No. _____

2882

P. O. Address _____

Queencity 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.