

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **548** Registrar's No. **2754**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		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 WEBSTER GROVES	c. LENGTH OF STAY (In this place) 2 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN UNIVERSITY CITY	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION GLENWOOD SANITORIUM		d. STREET ADDRESS (If rural, give location) 7355 MILAN	

3. NAME OF DECEASED a. (First) ELIZABETH b. (Middle) M. c. (Last) MYERS			4. DATE OF DEATH (Month) (Day) (Year) NOV 27 1954		
5. SEX F	6. COLOR OR RACE CAUC	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH JULY 2, 1892	9. AGE (In years last birthday) 62	10. IF UNDER 1 YEAR OF AGE: Hours 20 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) MISSOURI	
13a. FATHER'S NAME JAMES COLE			13b. MOTHER'S MAIDEN NAME Lucinda Whitworth		14. NAME OF HUSBAND OR WIFE Richard F. MYERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Yes (unknown)	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred MYERS University City Mo			
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE		
	DUE TO (c) CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL AS.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4200	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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?

22. I hereby certify that I attended the deceased from **NOV 15, 1954**, to **NOV 27, 1954**, that I last saw the deceased alive on **NOV 27, 1954**, and that death occurred at **6:55 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Edwin A. Schmidt, M.D.	(Degree or title)	23b. ADDRESS 13006 GRANT RD WEBSTER GROVES, MO.	23c. DATE SIGNED 27 Nov. 1954
24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE 11-30-54	24c. NAME OF CEMETERY OR CREMATORY Pacific Cemetery Pacific, Mo	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REP. 11/29/54	REGISTRAR'S SIGNATURE Robert R. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pro. L. ... Pacific, Mo	

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

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 Geo. L. Fisher

Licensed Embalmer No. 3008

P. O. Address Pacific M.

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.