

Health,
Welfare
Public
Service

FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3367

STATE FILE NUMBER 784

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Massac</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Joppa</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Childrens Hospital</u>			Length of stay in lb <u>24</u>	d. STREET ADDRESS (If outside, give location) <u>32</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>L.</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1953</u>		9. AGE (In years last birthday) <u>4</u>	10. FUNDING YEAR Months _____ Days _____ Hours _____ Min. _____	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>James E. Myers</u>		13b. MOTHER'S MAIDEN NAME <u>Helen Thomas</u>		14. NAME OF HUSBAND OR WIFE <u>Nil.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Nil.</u>	17. INFORMANT <u>James E. Myers, Joppa, Illinois.</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd and 3rd degree burns of 50% of Body.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <u>Injury sustained by wife in kitchen at Joppa, Illinois, on or about January 9, 1958</u>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>1. 9 58</u>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Joppa</u>		COUNTY <u>Illinois</u>	STATE
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>1210</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE <u>James E. Myers</u>				22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>1/22/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-22-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) (State) <u>Metropolis, Illinois.</u>		
24. FUNERAL DIRECTOR <u>Albert H. Hoppe</u>		ADDRESS <u>4700 Washington, Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 22 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Paul Smith, M.D.</u> S.P.		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Stanley H. Dixon*
Licensed Embalmer No. *4193*
P. O. Address *St. L.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.