Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-024891
STATE FILE NUMBER

FILED AUG 15 1958 Registration District No. 62 Primary Registration District No. 5238 Registrar's No. 17

1. PLACE OF DEATH
a. COUNTY Cedar
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jefferson Twp. Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 5 Miles East Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cedar
c. CITY OR TOWN Stockton 0200 0 Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 5 Miles East Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First LEWIS Middle FREDERICK Last MEYERS
4. DATE OF DEATH Month Aug. Day 2, Year 1958
5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH Feb. 25, 1900
9. AGE (In years last birthday) 58 IF UNDER 1 YEAR Months 5 Days 7 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm Owner
11. BIRTHPLACE (City and state or country) Dade County, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Frederick C. Meyers
13b. MOTHER'S MAIDEN NAME Kate Huffman
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 500-42-5376
17. INFORMANT Address Lohman Meyers, Stockton, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gun Shot (12 gague Shot Gun) INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) in Left Side (5th & 6th Rib)
DUE TO (c) 976 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☒ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 8-2-1958 5:00
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) FARM
20f. CITY, TOWN, OR LOCATION COUNTY Cedar STATE Mo.

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M D Gwinn, Coroner 3
22b. ADDRESS El Dorado Springs, Mo
22c. DATE SIGNED 8-2-1958

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8/6/1958
23c. NAME OF CEMETERY OR CREMATORY Stockton City Cemetery
23d. LOCATION (City, town, or county) (State) Stockton, Mo.

24. FUNERAL DIRECTOR ADDRESS Cantlon Fun. Home, Stockton, Mo.
25. DATE RECD. BY LOCAL REG. 8-9-58
26. REGISTRAR'S SIGNATURE Geneva Garrison

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

10

AUG 18 1958

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 John G. Carlton

Licensed Embalmer No. 4387

P. O. Address Stockton, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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