

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027928
STATE FILE NUMBER

FILED JUL 16 1958 Registration District No. 337 Primary Registration District No. 4496 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY <u>SHELBY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SHELBYVILLE, MO.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SHELBYVILLE, MO.</u> 1039 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PLEASANT HILL REST ROOM</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>SHELBYVILLE, MO.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>ROBERT LEE MYERS</u>			4. DATE OF DEATH Month Day Year <u>JULY 8 1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and state or country) <u>COOK HESTER, ILLINOIS</u>
13a. FATHER'S NAME <u>WILLIAM C. MYERS</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHRA HOOTEN</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
14. NAME OF HUSBAND OR WIFE <u>NEALIE MYERS</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>499-03-2858</u>		17. INFORMANT <u>Earl Myers, Shelbyville, Mo.</u>	
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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebro Sclerosis</u> DUE TO (c) <u>331X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY . Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 7-1958</u> to <u>July 8, 1958</u> and last saw him alive on <u>July 7-1958</u> Death occurred at <u>10:30 a.m.</u> on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. C. Wheeler M.D.</u>		22b. ADDRESS <u>Shelbyville Mo</u>	
22c. DATE SIGNED <u>7-8-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>July 9, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. SHELBYSVILLE, MO.</u>	
23d. LOCATION (City, town, or county) (State) <u>SHELBYVILLE, MISSOURI</u>		24. FUNERAL DIRECTOR ADDRESS <u>GREENING FUNERAL HOME</u> <u>SHELBYVILLE, MO.</u>	
25. DATE RECD. BY LOCAL REG. <u>7-10-58</u>		26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Charles O Green*

Licensed Embalmer No. *4625*

P. O. Address *Channah*

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.