

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010864

STATE FILE NUMBER

FILED MAR 27 1959

Registration District No. _____

Primary Registration District No. _____

Registration No. **2716**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1222 S. Boyle		d. STREET ADDRESS (If outside, give location) 1222 S. Boyle	

3. NAME OF DECEASED (Type or print) James H. Dyer			4. DATE OF DEATH Month Day Year 3/17/59		
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1876	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Rolla Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME John Dyer	13b. MOTHER'S MAIDEN NAME Miss Overlase	14. NAME OF HUSBAND OR WIFE Leatha Dyer
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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. None	17. INFORMANT Address Leatha Dyer 1222 S. Boyle
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 332+	
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.)
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20c. TIME OF INJURY Hour .Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK AT <input type="checkbox"/> WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from June 1958 , to 3/17/59 and last saw ^{her} him alive on 3/17/59 Death occurred at .9 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Maureen E. Green M.D.	22b. ADDRESS 1625 Tower Inn Cir	22c. DATE SIGNED 3/17/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/17/59	23c. NAME OF CEMETERY OR CREMATORY Rolla Cem.	23d. LOCATION (City, town, or county) (State) Rolla, Mo.
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24. FUNERAL DIRECTOR Rowland - Abernethy 404 Manchester	25. DATE RECD. BY LOCAL REG. MAR 17 '59	26. REGISTRAR'S SIGNATURE Lead Smith, M.D. MOE
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Lawrence M. Bills*
Licensed Embalmer No. *4375*
P. O. Address *St. Louis, 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.