

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024397

FILED VS JUL 21 1959

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 243 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cape Girardeau</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b <u>5 m. w</u>		c. CITY OR TOWN <u>Randles</u>		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>St. Francis Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Randal Twp</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Riley</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-86</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months <u>0</u>	Days <u>20</u>	Hours <u>-</u>	Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - SHOE FACTORY</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING SHOE FACTORY</u>		11. BIRTHPLACE (City and state or country) <u>St. Ilmo, Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Joseph Myers</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Josephine Loge</u>			14. NAME OF HUSBAND OR WIFE <u>Mary E. 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>493-26-9428</u>		17. INFORMANT <u>Mary E. Myers, R#2, Chaffee, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Unknown natural causes</u>							
DUE TO (b) <u>Invalidism</u>							<u>2 yrs</u>
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m.	Month, Day, Year _____						
20d. INJURY OCCURRED WHILE AT WORK <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>7-6-59</u> to <u>7-6-59</u> and last saw him/her alive on <u>7-6-59</u>							
Death occurred at <u>11:1 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>W. O. Finney M. D.</u>			22b. ADDRESS <u>106 S. Main Chaffee, Mo</u>			22c. DATE SIGNED <u>7-10-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-9-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Perkins Cemetery</u>		23d. LOCATION (City, town, or county) <u>Perkins</u>		STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>W. H. Morgan, Advance, Mo</u>			25. DATE RECD. BY LOCAL REG. <u>7-14-1959</u>		26. REGISTRAR'S SIGNATURE <u>Irma Kasten</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W.O. Finely, M.D.

02

EMBALMER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W^m H. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance,

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.