

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031161

FILED VS AUG 24 1959

Registration District No. 2-4 Primary Registration District No. 6093 Registrar's No. 131

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Saline</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall township</b>		Length of stay in 1b <b>One hour</b>		c. CITY OR TOWN <b>Marshall</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>One mile N.E. of Marshall</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>767 South Brunswick</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Henry</b> Last <b>Meyer</b>				4. DATE OF DEATH Month <b>August</b> Day <b>19th</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-20-1906</b>	9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months <b>53</b> Days	IF UNDER 24 HR Hours <b>53</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor, Pharmacist</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retail drug store</b>		11. BIRTHPLACE (City and state or country) <b>Tebbetts, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Arnold Meyer</b>			13b. MOTHER'S MAIDEN NAME <b>Amelia Helm</b>		14. NAME OF HUSBAND OR WIFE <b>Dorothy G. Meyer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World war 2</b>			16. SOCIAL SECURITY NO. <b>490-09-448I</b>		17. INFORMANT Address <b>Mrs Earl H. Meyer, Marshall, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5" Skull fracture. frontal bone</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Less than 1 hr</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Thrown from horse.</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)					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 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.) <b>Thrown from horse</b>					
20c. TIME OF INJURY <b>7-30 a.m.</b>	Hour Month, Day, Year <b>8-19-59</b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Stable</b>		20f. CITY, TOWN, OR LOCATION <b>Marshall, Miss.</b>		COUNTY STATE <b>Saline Miss</b>		
21. I attended the deceased from <b>made investigation 8-19-59</b> and last saw her alive on _____ Death occurred at <b>7:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>C. L. Lawless M.D., Coroner Saline Co</b>				22b. ADDRESS <b>Marshall Mo.</b>		22c. DATE SIGNED <b>8-20-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-21-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ridge Park cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Marshall, Missouri</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Campbell-Lewis, Marshall Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Aug 20-59</b>		26. REGISTRAR'S SIGNATURE <b>Carl S. Reed</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 1 1958

NOV 3 1959

NOV 14 1960

SEP 18 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

Ray, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed R.W. Campbell

Licensed Embalmer No. 3469

P. O. Address Marshall

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.