URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 1 1960

-60-024801

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6285

NDED

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 | Length of stay in 1b

c. CITY OR TOWN St. Louis | Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DE Paul Hosp | Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 4200 A Cleveland | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Thomas R Myers

4. DATE OF DEATH Month Day Year: 6/18/60

5. SEX: male

6. COLOR OR RACE: white

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8/15/1904

9. AGE (last birthday): 55

IF UNDER 1 YEAR: Months Days | IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator operator (grain)

10b. KIND OF BUSINESS OR INDUSTRY: grain elevator

11. BIRTHPLACE (City and state or country): Calloway Co. Ky.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: William Myers

13b. MOTHER'S MAIDEN NAME: Mary Ray

14. NAME OF HUSBAND OR WIFE: Helen Myers

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.: unk

17. INFORMANT Address: Helen Myers 4200a Cleveland

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) Cardiac Arrest. — Immed

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebrovascular Brain C — 6 months

DUE TO (c) Disseminated Metastasis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Emphysema Dehydration.

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 193.0

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

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.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from March - 1960, to June 18 60 and last saw him alive on June 18-60
Death occurred June 18-1960 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D.

22b. ADDRESS 634 N. Grand Blvd.

22c. DATE SIGNED 6-21-60

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE: 6/21/60

23c. NAME OF CEMETERY OR CREMATORY: Lakewood Park Cem.

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo

24. FUNERAL DIRECTOR ADDRESS: Edward Fendler 5611 South Grand Blvd.

25. DATE RECD. BY LOCAL REG.: JUN 20 1960

26. REGISTRAR'S SIGNATURE: Hoard Smith M.D. MBC

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed V. E. Morris

Signature of Student Embalmer

Licensed Embalmer No. 3360

P. O. Address St Louis M

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