

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 27 1960

-60-048494

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4509 Registrar's No. 107

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|---|---------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Sullivan</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Humphreys</u> | Length of stay in 1b <u>10 yrs</u> | c. CITY OR TOWN <u>Humphreys</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 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|------------------------------|---|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A</u> Last <u>MYERS</u> | | | 4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1960</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>9-18-1880</u> | 9. AGE (last birthday) <u>79</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Lumber</u> | | 11. BIRTHPLACE (City and state or country) <u>Sullivan Co Mo</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>W H Myers</u> | | 13b. MOTHER'S MAIDEN NAME <u>Margaret Williams</u> | | 14. NAME OF HUSBAND OR WIFE <u>Bertie Camp Myers</u> | | |

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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) | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Mrs Bertie Myers Humphreys Mo</u> Address |
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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u> | DUE TO (b) <u>Chronic Myocarditis</u> | <u>Instant</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (c) <u>Essential Hypertension</u> | <u>10-15 years</u> |
| 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 |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>3:30</u> a.m. <u>Am</u> Month, Day, Year | | |

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|--|--|--|---------------------|--------------------|
| 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 <u>Galt Mo</u> | COUNTY <u>Mo</u> | STATE <u>Mo</u> |
|--|--|--|---------------------|--------------------|

21. I attended the deceased from July 1950 to Dec 1960 and last saw her alive on 12-17-1960
 Death occurred at 3:30 Am m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>A.W. Etzel MD</u> (Degree or title) | 22b. ADDRESS <u>Galt Mo</u> | 22c. DATE SIGNED |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-20-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Stoney Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>Milan Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Rayne Funeral Home Galt Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>12-21-60</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckert</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 28 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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed PK Payne Jr

Licensed Embalmer No. 3400

P. O. Address Balt

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.