

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032547

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
Dr. S. Schreffel

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 906

STATE FILE NUMBER

AMENDED

FILED OCT 2 1961

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HANDLEY HOSP.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1219 N. MISSOURI
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last ANNA GERTRUDE MEYERS MYERS			4. DATE OF DEATH Month Day Year SEPT. 23 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/12/96	9. AGE (last birthday) 65	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) HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) INDIANAPOLIS, IND.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME WILLIAM SCOTT		13b. MOTHER'S MAIDEN NAME MAGGIE (UNKNOWN)		14. NAME OF HUSBAND OR WIFE OSCAR MEYERS (DEC.)		
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. NO		17. INFORMANT ELSIE Address MRS. WOOD CUNNINGHAM, NIANGUA, MO.		

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 Vascular Accident 98 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis unknown

DUE TO (c) _____

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

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No 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 SPRINGFIELD, MO.	COUNTY GREENE	STATE MISSOURI
21. I attended the deceased from <u>Sept 21, 61</u> to <u>9/23/61</u> and last saw her <u>alive</u> on <u>9/23/61</u> Death occurred at <u>7:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Deceased or title) <u>Carl H. Schreffel</u>	22b. ADDRESS <u>1620 N. Jefferson Springfield, Mo</u>	22c. DATE SIGNED <u>9/26/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/26/61	23c. NAME OF CEMETERY OR CREMATORY HAZELWOOD
23d. LOCATION (City, town, or county) SPRINGFIELD, MO.		(State)

24. FUNERAL DIRECTOR ADDRESS H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 9-27-61	26. REGISTRAR'S SIGNATURE <u>Effie S. Meester</u>
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DATE AMENDED: 10/9/61

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS:

INSTEAD OF: Meyers

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ: Myers

BY AFFIDAVIT OF Inf.

ITEM NO. 3 & 14

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 W. J. Mc Corm

Licensed Embalmer No. 2727

P. O. Address Spfld Mc

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.