

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033943

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 40

FILED SEP 26 1961

AMENDED

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>		Length of stay in 1b <u>6 wks</u>	c. CITY OR TOWN <u>Gerster</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Osceola Med. Hosp;</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 M-NE Gerster</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Jane</u> Last <u>Myers</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1961</u>		
5. SEX <u>Female</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>10/21/82</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Clair County Mo; USA</u>	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>John Shryver</u>		13b. MOTHER'S MAIDEN NAME <u>Axie Dunning</u>	
14. NAME OF HUSBAND OR WIFE <u>Vaun Myers</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Vaun Myers, Gerster Mo;</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO (b) <u>Fracture of femoral neck.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u> <u>5 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary emphysema</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <u>Fell at home</u>			
20c. TIME OF INJURY Hour <u>12:30</u> Month, Day, Year <u>Aug 31 61</u> p.m.		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.) <u>home</u>	
20f. CITY, TOWN, OR LOCATION <u>Gerster</u>		20g. COUNTY <u>St. Clair</u>		20h. STATE <u>MO</u>	
21. I attended the deceased from <u>9:45 P</u> on <u>July 55</u> to <u>7 Sept 61</u> and last saw her <u>live</u> on <u>7 Sept 61</u> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>			22b. ADDRESS <u>Osceola Mo</u>		22c. DATE SIGNED <u>8 Sept 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/10/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town, or county) (State) <u>Hickory County Mo</u>
24. FUNERAL DIRECTOR <u>Goodrich Funeral Home, Osceola Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-10-1961</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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 J. B. Bradish

Licensed Embalmer No. 3038

P. O. Address Oscoda MI

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.