

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township .....

Village .....

City .....

Registration District No. 791 File No. 2925

Primary Registration District No. 1003 Registered No. 72

(NO Jewish Hosp St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *Philip Frederick Myers*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 SINGLE ~~MARRIED~~ *married*  
(Write the word)

6 DATE OF BIRTH *March 17 1830*  
(Month) (Day) (Year)

7 AGE *87* yrs. *10* mos. *17* ds. IF LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work. *Clothing Merchant*  
(b) General nature of industry business, or establishment in which employed (or employer) *Prostatic Hypertrophy*

9 BIRTHPLACE (City or town, State or foreign country) *London England*

10 NAME OF FATHER *Henry Myers*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *England*

12 MAIDEN NAME OF MOTHER *Maria Sebaste*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *England*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Maurice A. Utzheimer*  
(Address) *6030 Waterman St*

15 Filed *JAN 2 1918* *Max E. Starkloff* Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan. 1 1918*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Dec. 16 1917* to *Jan. 1 1918*  
that I last saw him alive on *Jan 1 1918*  
and that death occurred, on the date stated above, at *2 48* p.m.

The CAUSE OF DEATH\* was as follows:  
*Prostatic Hypertrophy*  
*Complete Retention*  
*Supra-pubic Cystostomy*  
CONTRIBUTORY *acute Dilatation Cordae*  
(Duration).....yrs.....mos.....ds.  
(Secondary) *4-5 hrs.*  
(Duration).....yrs.....mos.....ds.

(Signed) *H. N. Lyon* M. D.  
*Jan 7 1918* (Address) *Humboldt Bldg*

\*State the Disease Causing Death, or, in cases from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?  
Former or usual residence *Jefferson Hotel*

19 PLACE OF BURIAL OR REMOVAL *Int Ohio Cemetery* DATE OF BURIAL *1/2 1918*

20 UNDERTAKER *Myer Ind Co* ADDRESS *429 N. Euclid*

