

1939 FEB 9

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

Do not use this space.

3411

1. PLACE OF DEATH

County Boone
Township Little River
City Wardell mo. (No. 2)

Registration District No. 1099
Primary Registration District No. 5868

File No. 3411
Registered No. _____
St. _____ Ward _____

2. FULL NAME Thomas Clyde Myroell

(a) Residence, No. Marshall mo. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 17 1935
7. AGE YEARS 3 MONTHS 11 DAYS 28
If LESS than 1 day, _____ hrs. or _____ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 9 1939
I HEREBY CERTIFY That I attended deceased from Jan 5 1939 to Jan 9 1939
I last saw him alive on Jan 8 1939. Death is said to have occurred on the date stated above, at 9 P. m.
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. #
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. #
10. Date deceased last worked at this occupation (month and year) #
11. Total time (years) spent in this occupation #

Bronchial Pneumonia
Date of onset _____
Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wardell mo.

13. NAME Nyle Myroell

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wardell

15. MAIDEN NAME Katherine Stetler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wardell mo.

17. INFORMANT Nyle Myroell
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Portageville mo. DATE 1-10 39

19. UNDERTAKER H. S. Smith
(ADDRESS) Carthageville mo.

20. FILED 1-20 39 J. A. Cray Registrar.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) J. E. Spivey M. D.
Wardell mo. (Address)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

107a.

RECEIVED

District Health Officer No. 3/

District File Number 39-2

Date Filed 2-1-29

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3400
Do not use this space.

1. PLACE OF DEATH

(a) County Pemissot Registration District No. 1099
(b) Township Little River Primary Registration District No. 5868
(c) City..... (d) Street No..... St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Thomas Clyde Myroel
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (use the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 28

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-9-19

22. I HEREBY CERTIFY, That I attended deceased from 19 _____ to 19 _____

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m. The principal cause of death and related causes of importance were as follows:

BRONCHIAL PNEUMONIA
No complications.
Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury....., 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. E. Babbett, M. D.
(Address) Wardell, Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Exact statement of OCCUPATION is very important.

