

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.

APR 12 1939

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

791 9140
1002 Do not use this space.
2905

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No.....
(c) City St. Louis, Mo. (d) Street No. City Infirmary 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 15 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sam Myatt

(a) Residence, No. 5800 Arsenal St. St. 13
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>March 5, 1880</u>		
7. AGE <u>59</u>	YEARS <u>X</u>	MONTHS <u>10</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Night Watchman</u>		11. Total time (years) spent in this occupation.....
9. Industry or business in which work was done, as saw mill, bank, etc. <u>Elks Club 5 yrs.</u>		
10. Date deceased last worked at this occupation (month and year).....		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dickson Tenn.</u>		
13. NAME <u>J. Albert Myatt,</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dickson Tenn.</u>		
15. MAIDEN NAME <u>Polly Holland</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dickson Tenn.</u>		
17. INFORMANT (ADDRESS) <u>E. Molony, 5800 Arsenal St.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Dickson, Tenn</u> DATE <u>3-30</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Albert H. Hoppe Inc. 4700 Washington Blvd.</u>		
20. FILED 19..... <u>J. B. Budach</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1937, to March 15, 1939
I last saw h. in alive on March 15, 1939. Death is said to have occurred on the date stated above, at 10:00 P.M.
The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis
Date of onset

Other contributory causes of importance:
Salt and Sugar

Name of operation..... Date of.....
What test confirmed diagnosis? H. P. S. S. S. Was there an autopsy? No

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? No
If so, specify.....
(Signed) William Sapsin, M. D.
(Address) 5600 Arsenal Street

MAR 27 1939

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Guy W. Wilkinson*
Licensed Embalmer No. *3575*
P. O. Address.....

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 this body is not embalmed, above space should be left blank.