

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

25660
 Do not use this space.

AUG 24 1939

1. PLACE OF DEATH

(a) County GREENE Registration District No. 320 315
 (b) Township 10 miles Primary Registration District No. 5443
 (c) City SPRINGFIELD (d) Street No. 12 miles West on 66 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

John Syler
 (a) Residence, No. 460 St. Louis, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 16th, 1923		
7. AGE 15	YEARS	MONTHS 8
		DAYS 25
IF LESS than 1 day,hrs. ormin.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student	
	9. Industry or business in which work was done, as saw mill, bank, etc. Student	
	10. Date deceased last worked at this occupation (month and year)	
11. Total time (years) spent in this occupation		
FATHER	12. BIRTHPLACE (CITY OR TOWN) Vandalia (STATE OR COUNTRY) Mo	
	13. NAME F. D. Syler	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) Vandalia (STATE OR COUNTRY) Mo	
	15. MAIDEN NAME Virden Akridge	
16. BIRTHPLACE (CITY OR TOWN) Vandalia (STATE OR COUNTRY) Mo		
17. INFORMANT John Syler Sr. (ADDRESS) St. Louis, Missouri		
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis, Mo. DATE Aug. 12, 1939		
19. FUNERAL DIRECTOR (NAME) H. H. Lohmeyer (ADDRESS) Springfield, Mo		
20. FILED 8/13 1939 Lucy E. Hoyal <i>Local Registrar</i>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **August 11th, 1939**

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw him ^{dead} ~~live~~ on **Aug. 11**, 19. **39** Death is said to have occurred on the date stated above, at **1230 Noon**
 The principal cause of death and related causes of importance were as follows:

Date of onset

Broken neck and crushed chest

Fractured Femur

Right arm torn from socket

Other contributory causes of importance:
Fractured Femur
Right arm torn from socket

Name of operation _____ Date of _____
 What test confirmed diagnosis **Clinical** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **Accident** Date of injury **Aug 11, 1939**
 Where did injury occur? **1.3 miles W. of Springfield Mo.**
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **Deceased, in a trailer, struck by truck.**
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? **X**
 If so, specify _____
 (Signed) **J. P. Ferguson Coroner**
 (Address) **604 E. Elm**

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.....

Licensed Embalmer No.....

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.