

Registration District No. 449

Primary Registration District No. 4267

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Leade
 (b) City or town Lebanon
 (c) Name of hospital or institution: Waller Memorial H
 (If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution 3 days
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Candeur
 (c) City or town Candeur
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Grace Ellen Myron
 (b) If veteran, name war _____
 (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 21
 year 1941 hour 9 minute 45 P. M.
 21. I hereby certify that I attended the deceased from 5-16
 _____, 1941, to 5-21, 1941
 that I last saw her alive on 5-21, 1941
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 (b) Name of husband or wife John Arthur Myron
 6. (c) Age of husband or wife if alive 36 years
 7. Birth date of deceased: July 18 1906
 (Month) (Day) (Year)

Immediate cause of death Septicemia
 Duration _____

8. AGE: Years 34 Months 10 Days 3
 If less than one day: _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____

9. Birthplace Candeur Co Ohio
 (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____
 12. Name William Holloway Owen
 13. Birthplace Candeur Co Ohio
 (City, town, or county) (State or foreign country)
 14. Maiden name Julia Francis Burns
 15. Birthplace Candeur Co Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant Julia Owen
 (b) Address Roach, Mo

17. (a) Burial (b) Date thereof May 23-41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Roach

18. (a) Signature of funeral director Bankson-Woolery
 (b) Address Candeur, Mo

19. (a) May 28 41 (b) J. A. McAuley
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

 (Specify type of place) (e) Means of injury _____
 23. Signature J. A. McAuley (M. D. or other) _____
 Address Lebanon Mo Date signed 5/22/41

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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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 Abbie Bankson Wolcott

Licensed Embalmer No. 2488

P. O. Address bandeuten, N.J.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18223

Registration District No. 449

Primary Registration District No. 4267

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Grace Ellen Myers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 10 3 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia
Due to Infection following abortion
Due to trauma induced

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
140 B

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. Summers (M. D. or other) _____
Address Lebanon Mo Date signed 9-18-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-18223