

FILED JAN 5 1943
Registration District No. 442

Primary Registration District No. 1000

Registrar's No. 1391

1. PLACE OF DEATH:

(a) County Buchanan,

(b) City or town St. Joseph,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1114 Edmond Street,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 50 years,
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan,

(c) City or town Saint Joseph,
(If outside city or town limits, write "RURAL")

(d) Street No. 1114 Edmond Street,
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Emma H. Myers,

3. (b) If veteran, name war None, 3. (c) Social Security No. None,

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married,

6. (b) Name of husband or wife George E. Myers, 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased May 31st, 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

76 6 20 hr. min.

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

10. Usual occupation At Home,

11. Industry or business _____

MOTHER { 12. Name Frederick Trachsel

FATHER { 13. Birthplace Unknown, Switzerland, 5
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Ringold

15. Birthplace Unknown, Switzerland, 5
(City, town, or county) (State or foreign country)

16. (a) Informant George E. Myers,
(b) Address 1114 Edmond Street,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/43
(Month) (Day) (Year)

(c) Place: burial or cremation St. Jo. Mem. Park Cem.

18. (a) Signature of funeral director Richard A. Barrman
(b) Address 319 So. 10th. Street,

19. (a) 12/22/43 (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21st.
year 1943 hour 9:00 minute 50 p. M.

21. I hereby certify that I attended the deceased from Feb, 1943, to Dec 21, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis

Due to Hypertension

Due to _____

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

Major findings: _____
Of operations _____
Of autopsy _____

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 0

23. Signature Dr. [Signature] (M. D. or other) MD
Address Kirkpatrick Building Date signed 12-22-43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

1233

St Joseph, Mo.

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 me

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

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 1391

Registration District No. 47 Primary Registration District No. 1000

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 Emma E. Meyer
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 _____ years
7. Birth date of deceased May 31 (Month) (Day) (Year)

8. AGE: Years 76 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 Feb Day 21 Year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Nov 1941 to Feb 21 1943
that I last saw him alive on cut your date 19____; and that death occurred on the date and hour stated above.
Immediate cause of death Heart sic cut vessel

Duration years
Due to hypertension years

Due to _____
Other conditions cut. sclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN 93d
Underline the cause to which death should be charged statistically.

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 Dr. Hoffman (M. D. or other) ms
Address St Joseph Mo Date signed 1-10-44

SUPPLEMENTARY

S-41677