DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 9 1944

Registration District No. 292

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5999

State File No. 4028

Registrar's No.

1. PLACE OF DEATH:

(a) County Ralls

(b) City or town Center, R F D
(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
In this community 56 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 87

(a) State Missouri (b) County Ralls

(c) City or town Center, R F D
(If outside city or town limits, write "RURAL")

(d) Street No. Center Township
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Charles Edwin Myers

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Tipton Myers

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Dec 23 1866 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	1	1	hr. min.

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

10. Usual occupation Farmer

11. Industry or business Own Farm

FATHER
12. Name Ben Myers
13. Birthplace Pa / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Agnes Rousick
(b) Address Washington, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Center Cemetery

18. (a) Signature of funeral director [signature]
(b) Address Center Mo

19. (a) Jan. 27, 1944 (Date received local registrar) (b) Mrs. Earl Perkinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1944 hour 6 minute 30p M.

21. I hereby certify that I attended the deceased from Dec. 10, 1943 to Jan. 24, 1944 that I last saw him alive on Jan. 22, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Angina Pectoris	5 mins
Due to: Unknown	
Due to: Unknown	
Other conditions: Unknown (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
Of autopsy: None	

94b

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. H. Brooks (M. D. or other) DO
Address Center, Mo. Date signed 1-26-44

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 8-17-39 I X19511

RECEIVED
District Health Officer No. 10
District File Number 2-44-319
Date Filed FEB 8 1944

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. 3356

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.