

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35067

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 468

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Oak Ridge Mo R I</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Francis Hospital</b> Length of stay in 1b <b>2</b>		d. STREET ADDRESS (If outside, give location) <b>Oak Ridge Mo R I</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marion</b> <i>First</i> <b>Daniel</b> <i>Middle</i> <b>Myers</b> <i>Last</i>		4. DATE OF DEATH <b>Oct 15 1957</b> Month <b>Oct</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 18 1884</b>
9. AGE (In years last birthday) <b>73</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b>27</b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Yount Mo</b>	
11. BIRTHPLACE (City and state or country) <b>Yount Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Franklin Myers</b>		14. MOTHER'S MAIDEN NAME <b>Malinda Loberg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-42-2480</b>	
17. INFORMANT <b>Willard Myers Jackson Mo</b> Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca Ovarynx</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <b>148X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>		
20c. TIME OF INJURY a. m. <b></b> p. m. <b></b> Hour <b></b> Month <b></b> Day <b></b> Year <b></b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b></b>	20f. CITY, TOWN, OR LOCATION <b></b>	COUNTY <b></b> STATE <b></b>
21. I attended the deceased from <b>Aug 1, 57</b> to <b>10-15-57</b> and last saw her alive on <b>10-15-57</b> . Death occurred at <b>3027 S. 8th</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Frank Hall M.D.</b>		22b. ADDRESS <b>Cape Girardeau</b>	22c. DATE SIGNED <b>10-17-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct 17 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion</b>	23d. LOCATION (City, town, or county) (State) <b>Old Appleton Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>M. Combs Funeral Home Jackson</b>		25. DATE RECD. BY LOCAL REG. <b>10-20-1957</b>	26. REGISTRAR'S SIGNATURE <b>O. C. Summers</b>

300 1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *BA Meyer*

Licensed Embalmer No. *308*  
P. O. Address *Jackson*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.