

Health & Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040555
STATE FILE NUMBER

FILED NOV 26 1958

Registration District No. 170 Primary Registration District No. _____ Registrar's No. 164

300 3
1-57

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Bexar</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Auglaize T.S.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>San Antonio</u> ⁸⁴²⁶		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Highway 66 East.</u>		Length of stay in 1b	d. STREET ADDRESS <u>1116 W. Gramerey</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ALVINA</u> Last <u>MYERS</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>14,</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1929</u>	9. AGE (In years for birthday) <u>29</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during last year, or during life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Uhrichsville, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>SAMUAL COORA</u>		13b. MOTHER'S MAIDEN NAME <u>MARY (UNKNOWN)</u>		14. NAME OF HUSBAND OR WIFE <u>Forrest Myers Jr.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>296-24-9056</u>	17. INFORMANT Address <u>-OHIO</u> <u>Mr. Forrest Myers Sr. Uhrichsville, -O</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Fracture</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1mm.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Automobile Accident.</u>			
20c. TIME OF INJURY Hour <u>XX</u> Month, Day, Year <u>2:25 11/14/58</u> p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>6 miles east of Lebanon, Mo. on U.S. Highway 66</u>		20f. CITY, TOWN, OR LOCATION <u>Lebanon, Mo.</u> COUNTY <u>LACLEDE</u> STATE <u>MISSOURI</u>			
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>2:25 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Stanley R Palmer, Coroner</u> (Degree or title)			22b. ADDRESS <u>Lebanon, Mo.</u>		22c. DATE SIGNED <u>11-15-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify if any)	23b. DATE <u>11/15/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Uhrichsville, Ohio</u>	
24. FUNERAL DIRECTOR <u>S R Palmer</u> ADDRESS <u>Lebanon, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-15-1958</u>		26. REGISTRAR'S SIGNATURE <u>Milla L. Hay</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

Date Filed

NOV 24 1953

VS MAY 19 1959

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 *Stanley R. Palmer*

Licensed Embalmer No. *4810*
P. O. Address *Lebanon, Mo*

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.