

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002642

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural St. Francois</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>ELUIVS</u> <u>940</u> 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>Mineral Area Osteopathic Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (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>EDNA</u> Middle <u>MAE</u> Last <u>MEYERS</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>2</u> Year <u>1959</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>JULY 22, 1900</u>	9. AGE (In years last birthday) <u>58</u>	F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MADISON CO, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	

13a. FATHER'S NAME <u>A. T. REUELLE</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH WHITEHEAD</u>		14. NAME OF HUSBAND OR WIFE <u>GILBERT MEYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Gilbert Meyer Elvins, Mrs.</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>(a) Acute Circulatory Failure</u> <u>(b) Cerebral Anoxia</u> <u>(c) Hypostatic pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>(d) Combined Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>6 hours</u> <u>12 hours</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2901</u>			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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from 12-18-1954 to 2-2-1959 and last saw her alive on 2-2-1959  
Death occurred at 1:50 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. W. Morris, D.O.</u>	(Degree or title)	22b. ADDRESS <u>210 W. Main St., Flat River, Mo.</u>	22c. DATE SIGNED <u>2-2-1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN. 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>REUELLE</u>	23d. LOCATION (City, town, or country) (State) <u>Fredricktown MO.</u>
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24. FUNERAL DIRECTOR <u>Raymond Caldwell and Sons</u>	ADDRESS <u>1318 Rivington</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 6, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Ethel R. Riddle</u>
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300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *R. Caldwell* .....

Licensed Embalmer No. *2531* .....

P. O. Address *Flat River, 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.