Health, & Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006277
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 178 Primary Registration District No. _____ Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY Lewis
b. CITY OR TOWN Lewistown (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Prairie View REst Home Length of stay in 1b 2½ yr

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Knox
c. CITY OR TOWN 6 5 2 0 0 Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 5 Mi Ne Baring Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First FERDINAND Middle Last MYERS
4. DATE OF DEATH Month Day Year Feb 23, 1959
5. SEX M 6
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH June 11, 1871
9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Scotland County 6
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Wm. Jasper Myers
13b. MOTHER'S MAIDEN NAME Sarah Walker
14. NAME OF HUSBAND OR WIFE Della Matlick Myers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Loyd Myers Address Baring, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-Vascular accident — INTERVAL BETWEEN ONSET AND DEATH 2 days
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) Influenza 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 July 1958, to 23 Feb 59 and last saw ~~her~~ him alive on 22 Feb 59
Death occurred at DOA. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John W Wills (Degree or title) D.O. 2
22b. ADDRESS Lewistown MO
22c. DATE SIGNED 26 Feb 59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 26 Feb 1959
23c. NAME OF CEMETERY OR CREMATORY Pauline Cemetery
23d. LOCATION (City, town, or county) (State) Rutledge, Missouri

24. FUNERAL DIRECTOR A.B. Simer ADDRESS Edina, Mo.
25. DATE RECD. BY LOCAL REG. 3-2-'59
26. REGISTRAR'S SIGNATURE P.W. Jennings, M.D. E.L.
(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. 5041
P. O. Address Edina, Mn

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.