

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016572

STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. 366 Primary Registration District No. Registrar's No. 42

300
-57

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY WASH.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CADET RT. #1 KINGSTON		c. CITY OR TOWN CADET RT. #1 110-0 0	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HY 21 + 104		d. STREET ADDRESS (If outside, give location) HY'S 21 + 104	
3. NAME OF DECEASED (Type or print) First Middle Last EDITH REBECCA MYERS		4. DATE OF DEATH Month Day Year MAY 3 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 11, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 80
11. BIRTHPLACE (City and state or country) TERRE HAUTE, IND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME FRANK STANLEY		13b. MOTHER'S MAIDEN NAME ELIZABETH DENNAHY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		14. NAME OF HUSBAND OR WIFE JOHN MYERS	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT JOHN MYERS Address CADET MO. RT. #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis with Myocardial infarction. DUE TO (b) arteriosclerosis coronary arteries. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			INTERVAL BETWEEN ONSET AND DEATH 30 minutes unknown
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 May 3, 1959 to May 3, 1959 and last saw her alive on May 3, 1959. Death occurred at 11 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thomas A. Donnell MD		22b. ADDRESS Desoto Mo.	
		22c. DATE SIGNED 5-4-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAY 6, 1959	23c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS	23d. LOCATION (City, town, or county) (State) 7901 GRAVOIS ST. LOUIS MO.
24. FUNERAL DIRECTOR DONNELL B. DIETRICH		25. DATE RECD. BY LOCAL REG. 5/5/59	
		26. REGISTRAR'S SIGNATURE Helen S. Suddell	

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 James B. Steiner

Licensed Embalmer No. 4104
P. O. Address Adelto 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.