

# MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

## =61-029960

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 67

AMENDED

**FILED SEP 1 1961**

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Lafayette</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lexington</b>		Length of stay in 1b <b>three years</b>	c. CITY OR TOWN <b>Lexington</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lexington Memorial H OS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.R.2 Lexington, Mo.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Charles Patrick Myers</b>			4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>January 23, 1909</b>	9. AGE (last birthday) <b>52</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (City and state or country) <b>Afton, Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Wallace Myers</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Victoria Malone</b>		14. NAME OF HUSBAND OR WIFE <b>Vera Jean Myers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W.W.II</b>		16. OFFICIAL CERTIFICATE NO.		17. INFORMANT Address <b>Mrs. Vera Jean Myers Lexington, Mo.</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>Acute posterior wall myocardia infarction 9 days</b>					INTERVAL BETWEEN ONSET AND DEATH
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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ s.m. _____ p.m. _____	Month, Day, Year _____				
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.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>8-14-61</b> to <b>8-22-61</b> and last saw her alive on <b>8-22-61</b>		Death occurred at <b>9:00</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Ben H. Brosher</b> (Degree or title)		22b. ADDRESS <b>Lexington, Missouri</b>		22c. DATE SIGNED <b>8/23/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-24-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lexington Memory Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Lexington Missouri</b>	
24. FUNERAL DIRECTOR <b>Vaughn-Walker</b> ADDRESS <b>Lexington, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-24-61</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 SEP 5

1961 SEP 6

1961 NOV 28

1962 FEB 15

**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 Paul H. Wilson, Student Embalmer No. 639

working under my personal supervision.

Student Paul H. Wilson  
Signature of Student Embalmer

Signed Harold L. Larkner

Licensed Embalmer No. 4588

P. O. Address Lexington, 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.