

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017296

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 157

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 1 1963

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>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FARMINGTON, RURAL</u> Length of stay, in 1b <u>ONE WEEK</u>		c. CITY OR TOWN <u>MINE LA MOTTE</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>THOMAS DELL NURSING HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES EMORY MYERS</u>			4. DATE OF DEATH Month Day Year <u>APRIL 2 1963</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-1896</u>	9. AGE (last birthday) <u>66</u>	10. IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min. <u>10 20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>MINE LA MOTTE, MO</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOSEPH MYERS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY HENDERSON</u>	
14. NAME OF HUSBAND OR WIFE <u>NONE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>YES W.W.I</u>			
17. INFORMANT <u>MRS. BEULAH MATTHEWS</u>				Address <u>604 West MAIN ST, FREDERICKTOWN, MO</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) Anterior circulation - Generalized

INTERVAL BETWEEN ONSET AND DEATH 3 yrs

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)
Chronic Brain Syndrome associated with Circulatory Disturbance

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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.) <u>with Cerebral arteriosclerosis</u>
20c. TIME OF INJURY Hour _____ a.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 <u>Feb. 19, 1963</u> to <u>April 2, 1963</u> and last saw him <u>her</u> alive on <u>April 2, 1963</u> Death occurred at <u>3 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>Lanning - mo</u>	22c. DATE SIGNED <u>4/3/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-4-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MINE LA MOTTE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MINE LA MOTTE, MO</u>
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24. FUNERAL DIRECTOR <u>SAM NAJIM, JR., FREDERICKTOWN, MO</u>	25. DATE RECD. BY LOCAL REG. <u>Apr. 3, 1963</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
1 0940
2 0620
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4 0
5 0
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7 0
8 2
9334X
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12 86-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MAY 2 1963

0840
0220
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0-22

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

Sam Sajin, Jr

Licensed Embalmer No. 4299

P. O. Address Fredericktown, 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.