

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 2 1948

Registration District No. 360

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6225

State File No. 18489

Registrar's No. 74

1. PLACE OF DEATH:

(a) County German  
(b) City or town Marion, Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital #32  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 31 yrs 3 days  
(Specify whether  
In this community 31 years 3 days  
years, months or days)

3. (a) PRINT FULL NAME JOAN MYERS

8. (b) If veteran, name war ✓ 8. (c) Social Security No. ✓

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased 8-29-1879  
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days 24 If less than one day hr. min.

9. Birthplace California Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Teacher

11. Industry or business School

12. Name William Meyer

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Meyer

15. Birthplace W. Va.  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital record

(b) Address Nevada Mo.

17. (a) Burial (b) Date thereof 5-25-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation California Mo.

18. (a) Signature of funeral director Harry F. Brown

(b) Address Nevada Mo.

19. (a) 5-25-48 (b) Halcyon Yancy  
(Date received local registrar) (Registrar's signature) 331

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Moniteau  
(c) City or town California 68  
(If outside city or town limits, write "RURAL")  
(d) Street No. ✓ (If rural, give location)  
(e) If foreign born, how long in U. S. A. 210 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29  
year 1948 hour 2 minute 15 A. M.

21. I hereby certify that I attended the deceased from ✓ 19 ✓ to ✓ 19 ✓  
that I last saw her alive on 5-22- 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of uterus  
Type undetermined

Due to ✓

Due to ✓

Other conditions ✓  
(Include pregnancy within 3 months of death)

Major findings: ✓  
Of operations ✓

Of autopsy ✓

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? ✓ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

(Specify type of place)  
While at work? ✓ (e) Means of injury ✓

23. Signature W. Hall (M. D. or other) 0  
Address Nevada Mo. Date signed 5-25-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
District Health Officer No. 7  
District File Number 5-42-578  
Date Filed 6-1-48

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 me

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Mike E. Ferry  
Licensed Embalmer No. 1432  
P. O. Address Nevada 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 this body is not embalmed, above space should be left blank.