

OHIO DEPARTMENT OF HEALTH

DIVISION OF VITAL STATISTICS

CERTIFICATE OF DEATH

Reg. Dist. No. **3101**

Primary Reg. Dist. No. _____

State File No. **57097**Registrar's No. **5653**

1. PLACE OF DEATH a. COUNTY Hamilton			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission). a. STATE Ohio b. COUNTY Hamilton		
b. CITY (If outside corporate limits, write RURAL, OR and give township); VILLAGE Sincinnati		c. LENGTH OF STAY (In this place) 297	c. CITY (If outside corporate limits, write RURAL, and give township); OR VILLAGE Cincinnati, Ohio 16		d. STREET (If rural, give location); ADDRESS 212 Green St.
d. FULL NAME OF HOSPITAL OR INSTITUTION Dunham Hospital					
3. NAME OF DECEASED (Type or print) Arthur Myers			a. (First)	b. (Middle)	c. (Last)
4. DATE OF DEATH Sept. 27 1951			(Month)	(Day)	(Year)
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 9-3-1898	9. AGE (In years last birthday) 53	10. MONTHS 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Maintenance Work	10b. KIND OF BUSINESS OR INDUSTRY Midwest Sporting Service	11. BIRTHPLACE (State or foreign country) Bath County, Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Myers (dec)			14. MOTHER'S MAIDEN NAME Effie Day (dec)		
15. WAS DECEASED EVER IN U. S. ARMED SERVICES? No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE Mary Freda Millerbrick		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary tuberculosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Hypertensive Cardiovascular Disease DUE TO (c) 002X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 19 1/2 hrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, forest, etc.)	21c. (CITY, VILLAGE, OR TOWNSHIP)	(COUNTY)	(STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at <input type="checkbox"/> Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/4 1950 , to 9/27 1951 , and that death occurred at 6:00 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE R. E. Wehr		(Degree or title) M.D.	23b. ADDRESS Dunham Hospital		23c. DATE SIGNED 9/27/51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-29-51	24c. NAME OF CEMETERY OR CREMATORY Salt Lick Cemetery		24d. LOCATION (City, town, or county) (State) Salt Lick, Kentucky	
BIRTH NO. Do not write in this space			NAME OF EMBALMER Kermit Frey	(LIC. NO.) 4785-A	
DATE REC'D BY LOCAL REG. Oct 2 1951	REGISTRAR'S SIGNATURE R. E. Wehr md		25. FUNERAL DIRECTOR'S SIGNATURE Anthony Reedinger (LIC. NO.)		

MARGIN RESERVED FOR BINDING

THIS CERTIFICATE SHALL BE PRINTED LEGIBLY OR TYPEWRITTEN IN UNFADING INK.

V.S. 11