

Registration District No. 399

Primary Registration District No. 1002

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

REC'D DEC 11 1940

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Conley Clinical Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether  
In this community 7 years  
years, months or days)

3. (a) PRINT FULL NAME MYRTLE MAY SALYER

3. (b) If veteran, name war none 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Eugene Salyer 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased September 26, 1900  
(Month) (Day) (Year)

8. AGE: Years 40 Months 1 Days 7 If less than one day hr. min.

9. Birthplace Vernon Texas  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housekeeping

12. Name James Clinton Drake

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

14. Maiden name Minnie May Rosson

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

16. (a) Informant Mr. Eugene Salyer

(b) Address 1111 Bennington, K.C.Mo.

17. (a) Removal (b) Date thereof 11-4-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oklahoma City, Oklahoma

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Independence Ave. K.C.Mo.

19. (a) 11-3-40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1111 Bennington  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 3rd  
year 1940 hour 3 o'clock minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 29  
1940 to Nov 3 1940  
that I last saw her alive on Nov 3 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Parenchymatous Nephritis (Uremia)  
Due to Chronic Myocarditis  
Due to 92c

Other conditions  
(Include pregnancy within 3 months of death)

Major findings: Recent eroded cerebri  
Chronic Hypertrophic  
retained

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?  
361 (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury 3  
23. Signature L. J. Graham (M. D. or other) 20  
Address 814 Chamber St Date signed 11-3-40

DEC 13 1951

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.....

*Joe B. Yoder*....., Registered Apprentice No. *# 233*  
working under my personal supervision.

Signed *J. Sheil*.....  
Licensed Embalmer No. *# 3625*  
P. O. Address *H. C. 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, fact should be so stated above.