S. No. 2
11-10-39
5-17-39
I X21492

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

FILED JUN 9 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18 194

Registration District No. 426 Primary Registration District No. 4257 Registrar's No. 9

1. PLACE OF DEATH:
(a) County: Johnson
(b) City or town: Chilhowee
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City, Mo.
(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.? / years.

3. (a) PRINT FULL NAME: Belle Salyer
3. (b) If veteran, name war: **
3. (c) Social Security No.: **
4. Sex: Female /
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Salyer Lee
6. (c) Age of husband or wife if alive: 76 years
7. Birth date of deceased: Sept (Month) 14 (Day) 1865 (Year)
8. AGE: Years 75 Months 8 Days 1 If less than one day ____ hr. ____ min.
9. Birthplace: Komo (City, town, or county) / Ind (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business ____
FATHER 12. Name: B.W. Crume
FATHER 13. Birthplace: / Ind (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Anna Simpson
MOTHER 15. Birthplace: unknown / Ky (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs G.M. Kendall
(b) Address: Chilhowee. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-17-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Warrensburg, Mo
18. (a) Signature of funeral director: O. L. Cook
(b) Address: Chilhowee, Mo
19. (a) MAY 16 1941 (Date received local registrar) (b) O L Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 15th 41 year: 1941 hour: 2 J minute: 10 P M.
21. I hereby certify that I attended the deceased from Nov 1- 11/1, 1941, to May 15, 1941; that I last saw h. alive on May 15th, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Progressive Rangrene of Foot
Due to: Cerebral & General arterio Sclerosis
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____
Major findings: Of operations: ____ Of autopsy: ____

Duration

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? ____ (Specify type of place)
While at work? (e) Means of injury: ____
23. Signature: G. M. Kendall (M. D. or other) D
Address: Chilhowee Mo Date signed: 5/16-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number 16-4-41
Date Filed

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~~ ....., Registered Apprentice No. ..... working under my personal supervision.

Signed O. L. Cook

Licensed Embalmer No. 2708

P. O. Address Chilhowee-T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.