

No. 2
-5-42
17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31880**

FILED **OCT 13 1943** 157

Primary Registration District No. **3028**

Registrar's No. **188**

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Carthage**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 hours**
(Specify whether
In this community **1 year**
years, months or days)

3. (a) PRINT FULL NAME **Mary Ruth 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 **Sherman Salyer**
6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **March 23 1911**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	32	6	7	hr. min.

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

10. Usual occupation **at home**

11. Industry or business **--**

12. Name **James Shae**

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

14. Maiden name **unknown**

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

16. (a) Informant **Sherman Salyer**

(b) Address **Carthage, Missouri**

17. (a) **Burial** (b) Date thereof **Oct 3 - 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Hill Cemetery**

18. (a) Signature of funeral director **Knell Mortuary**
(b) Address **Carthage, Missouri**

19. (a) **Oct 1, 1943** (b) **Elizabeth Coupland**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper 049**
(c) City or town **Carthage**
(If outside city or town limits, write "RURAL")
(d) Street No. **1300 Garrison Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **30**
year **1943** hour **10** minute **30** P.M.

21. I hereby certify that I attended the deceased from **Sept 30 1943** to **Sept 30 1943**
that I last saw her alive on **Sept 30 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute fulminant**
acute hemorrhagic nephritis
acute hemorrhagic cystitis
Due to **Acute splenitis**
acute hemorrhagic gastritis
Due to **Chronic upper pleuritis**
Fibroid uterus
Other conditions (Include pregnancy within 3 months of death) **✓**

PHYSICIAN
Major findings:
Of operations
Of autopsy **As of above**
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?

While at work (Specify type of place) (a) Means of injury

23. Signature **R. A. Webster** (M.D.)
Address **Carthage, Mo.** Date **Sept 30 1943**

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

MOTHER FATHER

43-9-842

OCT 25 194

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..... *Emmal R. Kneel*

Licensed Embalmer No. *391*

P. O. Address..... *Barthage, 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.

Registration District No. 15-7 Primary Registration District No. 3028

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary Ruth Salyer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 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 Mar 23 (Month) (Day) (Year)

8. AGE: Years 32 Months 6 Days _____ (Unless than one day) min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 10 year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I observed _____ on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____
Due to acute nephritis
Due to n.m.o.
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically. 130

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? _____

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

23. Signature R. A. Webster (M. D. or other) _____
Address Carthage Mo Date signed Oct 15 43

SUPPLEMENTARY

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

NOV 9 1948

31880