S. No. 2
M—9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27306

Registration District No. 22 Primary Registration District No. 1000 Registrar's No. 886

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) ~~City or town~~ St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 10 M. 25 day (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 11
(c) City or town Kansas City 7
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Jay Saylor
3. (b) If veteran, name war 7
3. (c) Social Security No. 7
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced ? 9
6. (b) Name of husband or wife ?
6. (c) Age of husband or wife if alive years
7. Birth date of deceased not given (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day
not given hr. min.

9. Birthplace Not given 9
(City, town, or county) (State or foreign country)
10. Usual occupation not given
11. Industry or business
FATHER
12. Name Not given
13. Birthplace Not given 9
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name not given
15. Birthplace not given 9
(City, town, or county) (State or foreign country)
16. (a) Informant Record Hospital
(b) Address St Joseph Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 9-6-44 (Month) (Day) (Year)
(c) Place: burial or cremation State Hosp #2
18. (a) Signature of funeral director Stamey Funeral Home
(b) Address St Joseph Mo
19. (a) 9/6/44 (Date received local registrar) (b) Helen S. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1
year 1944 hour 3 minute a M.
21. I hereby certify that I attended the deceased from 8-29, 1944, to 9-1, 1944
that I last saw him alive on 8-31, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Bronchial
Due to Bed ridden for all
Due to of Stay in Hospital
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.

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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 E E Salyer 0 (M. D. ~~another~~)
Address St Joseph Mo. Date signed

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(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.