

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED AUG 19 1946 THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26589**

Registration District No. **70** Primary Registration District No. **4124** Registrar's No. **47**

1. PLACE OF DEATH: **Blank**
(a) County **Blank**
(b) City or town **Kahoka**
(c) Name of hospital or institution: **Blank**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Blank**
In this community **Blank**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Blank 23**
(c) City or town **Kahoka**
(d) Street No. **Blank**
(e) Citizen of foreign country? **no**
If yes, name country **Blank**

3. (a) PRINT FULL NAME **Mary W. Salyers**
(b) If veteran, name war **Blank**
(c) Social Security No. **Blank**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **9th**
year **1946** hour **9** minute **P** M.
21. I hereby certify that I attended the deceased from **8-1-42**
to **6-9-1946**
that I last saw her alive on **6-9-1946**
and that death occurred on the date and hour stated above.

4. Sex **F. W.** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife **Frank Salyers**
6. (c) Age of husband or wife if alive **Blank** years
7. Birth date of deceased **Feb 6 1876**
(Month) (Day) (Year)

Immediate cause of death **myocarditis**
Due to **Sarcoma of uterus + Bladder**
Due to **Blank**

8. AGE: Years **70** Months **4** Days **3**
If less than one day **Blank** hr. **Blank** min.

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

10. Usual occupation **at Home**

11. Industry or business
12. Name **Henry Zwilling**
13. Birthplace **Germany**
14. Maiden name **Kathern Billias**
15. Birthplace **New York New York**

16. (a) Informant **Mrs. Jacob Hobb**
(b) Address **Kahoka Mo.**

17. (a) **Burial** (b) Date thereof **6-11-46**
(c) Place: burial or cremation **Kahoka Cemetery**

18. (a) Signature of funeral director **Fred Karle**
(b) Address **Kahoka Mo.**
19. (a) **6/10-46** (b) **J. H. Bridges**
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months) **Blank**
Major findings: Of operations **Blank**
Of autopsy **Blank**
PHYSICIAN **Blank**
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) **Blank**
(b) Date of occurrence **Blank**
(c) Where did injury occur? **Blank**
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Blank**

While at work? **Blank** (Specify type of place) (z) Means of injury **2**
23. Signature **J. H. Bridges** (M.D. or other) **Blank**
Address **Kahoka Mo.** Date signed **6-10-46**

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

25435

RECEIVED
District Health Officer No. 10
District File Number 8-46-152
Date Filed AUG-1-4-1948

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..... Fred J. Karle
Licensed Embalmer No. 1023
P. O. Address Kokoto 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. 70 Primary Registration District No. 4124

1. PLACE OF DEATH:
(a) County Clark
(b) City or town Kahoka
(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)

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 _____

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____, day _____, year 1944 (hour _____ minute _____ M. _____)
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

Due to CANCER OF UTERUS + SIGMOID COLON
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations H&A
Of autopsy _____

7. Birth date of deceased: Feb 6 (Month) (Day) (Year)
8. AGE: Years 70 Months _____ Days _____ If less than one day _____ hr. _____ min. _____

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

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

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 H. Shaming (M. D. or other) _____
Address Kahoka Mo Date signed 8-28-46

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

26589