

FILED OCT 28 1946

State File No. \_\_\_\_\_

Registration District No. 2

Primary Registration District No. 5014

Registrar's No. 96

1. PLACE OF DEATH:  
(a) County Andrew  
(b) City or town Rural Jefferson Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2 miles No. of Industrial City  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
life (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Joseph E. Sayles  
(b) If veteran, name war none  
(c) Social Security No. 497-12-0475

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month October day 8th  
year 1946 hour 7 minute 45 P. M.  
21. I hereby certify that I attended the deceased from found dead  
Did not attend him to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Mary E. Sayles  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased May 14 1933  
(Month) (Day) (Year)

Immediate cause of death Mitral insufficiency  
Duration 2 yrs

8. AGE: Years Months Days If less than one day  
63 4 24 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

MOTHER FATHER

9. Birthplace Andrew County Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation farmer  
11. Industry or business farming  
12. Name Lawrence Sayles  
13. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Bridgie Tracy  
15. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Joseph E. Sayles  
(b) Address R.R. #2 St. Joseph, Mo.  
17. (a) burial (b) Date thereof 10/10/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park  
18. (a) Signature of funeral director Heaton Beale & Bowman  
St. Joseph, Mo.  
(b) Address \_\_\_\_\_  
19. (a) 10-14-1946 (b) Silvan Sparks  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Mitral insufficiency  
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? (C)  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature P. P. Kelley (M. D. or other) Surgeon General  
Address St. Joseph, Mo. Date signed 10-8-46

DISTRICT HEALTH OFFICE  
CITY OF MO.

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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.....

*Eugene Wood*

Licensed Embalmer No. *3804*

P. O. Address *314 So 10th St. Joseph*

**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. *2*

Primary Registration District No. *501x*

Registrar's No. *96*

1. PLACE OF DEATH:

(a) County *Andrew Rural*  
(b) City or town *Rural*  
(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 *Joseph E Saylor*

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced. *M*

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. *18* years

7. Birth date of deceased. *May 14* (Month) *1946* (Year)

8. AGE: Years *63* Months Days If less than one day hr. 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  
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) *10-14-46* (Date received local registrar) (b) *Lilleau Sparks* (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 *Nov* day *14* year *1946* hour *9* minute *15* M.

21. I hereby certify that I attended the deceased from *9* to *19* that I last saw him *alive* on *19* and that death occurred on the date and hour stated above.

Immediate cause of death. *Heart* Duration

Due to

Due to

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.

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

MOTHER FATHER

32578