

FILED MAY 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12912

State File No.

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 182

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give town) INDEPENDENCE	c. LENGTH OF STAY (In this place township) 21 YEARS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN INDEPENDENCE	
d. FULL NAME OF (If not in hospital, or institution, give street address or location) HOSPITAL OR INSTITUTION BEST HAVEN : 9904 WINNER ROAD		d. STREET ADDRESS (If rural, give location) 9904 WINNER ROAD	

3. NAME OF DECEASED (Type or Print) a. (First) CHRISTIANA b. (Middle) c. (Last) SALYARDS	4. DATE OF DEATH (Month) APRIL (Day) 16 (Year) 1951
---	---

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MARCH 30 1861	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	--	--	--	-----------------------------------	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) ROCHELLE ILLINOIS	12. CITIZEN OF WHAT COUNTRY? USA
--	--	---	--

13a. FATHER'S NAME CHARLES STEDMAN	13b. MOTHER'S MAIDEN NAME KATHERINE	14. NAME OF HUSBAND OR WIFE RICHARD SALYARDS
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME RLDS CHURCH RECORDS	ADDRESS INDEPENDENCE MO.
---	--	---	------------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arteriosclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 3/19 1948, to 4/16, 1951, that I last saw the deceased alive on 4/1, 1951, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Vance E. Link, M.D.	(Degree or title)	23b. ADDRESS Independence, Mo.	23c. DATE SIGNED 4/16/51
--	-------------------	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-18-51	24c. NAME OF CEMETERY OR CREMATORY MOUND GROVES	24d. LOCATION (City, town, or county) (State) INDEPENDENCE JACKSON MO
--	-----------------------------	---	---

DATE REC'D BY LOCAL REG. Apr 18 - 1951	REGISTRAR'S SIGNATURE [Signature]	3-4-55 FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Independence Mo
--	---	---	-----------------------------------

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

485
4

APR 27 1950

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Marion Weir*
Student Embalmer No.....

Licensed Embalmer No. *3156*

P. O. Address *Independence*

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.