

FILED DEC 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43889

BIRTH NO. _____ REG. DIST. NO. 370 PRIMARY REG. DIST. NO. 4540 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY WAYNE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY WAYNE	
b. CITY OR TOWN GREENVILLE		c. CITY OR TOWN GREENVILLE	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 110	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) CYRUS	a. (First)	b. (Middle)	c. (Last) Meloy	4. DATE OF DEATH 12-8-57	(Month)	(Day)	(Year)
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 1-10-1869	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 10 Days 29	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois - 1	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME TAYLOR Meloy	13b. MOTHER'S MAIDEN NAME EVILYN SATTERY	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Shuman Meloy	ADDRESS Greenville Mo
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mitral Stenosis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	ANTECEDENT CAUSES Morbidity 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. agg		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 410X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Apr**, 1948, to **Dec**, 1957, that I last saw the deceased alive on **Dec 7**, 1951, and that death occurred at **3:30** m., from the causes and on the date stated above.

23a. SIGNATURE Adam F. Wagner, M.D. (Degree or title)	23b. ADDRESS Greenville Mo	23c. DATE SIGNED 12-10-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-10-57	24c. NAME OF CEMETERY OR CREMATORY Greenville Center	24d. LOCATION (City, town, or county) (State) Greenville - MO
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DATE REC'D BY LOCAL REG. 12-11-57	REGISTRAR'S SIGNATURE Mabel Beasley	341	25. FUNERAL DIRECTOR'S SIGNATURE Lloyd Russell	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

DEC 14 1961

WAYNE CO. HEALTH CENTER

FILE No. 1251-77

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 _____

M

working under my personal supervision.

Student Embalmer No.

Signed _____

Leroy J. Tyler

Licensed Embalmer No. *1001 Ark*

Signed _____
Student Embalmer

P. O. Address *Piggott Ark.*

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.

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