

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

BIRTH NO. _____ REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 5040 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Barry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Exeter		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Exeter twp.	
c. LENGTH OF STAY (in this place) 26 yrs.		d. STREET ADDRESS (If rural, give location) 650	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) Harvey		b. (Middle) Alyea	
c. (Last) Alyea		4. DATE OF DEATH (Month) (Day) (Year) 5-6-1954	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 10-6-1885
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Theodore Alyea		13b. MOTHER'S MAIDEN NAME Mary E. Bales	
14. NAME OF HUSBAND OR WIFE Lillie Alyea			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Ruby Fehring, Fairview, Mo. R.F.D.		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Angina Pectoris		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
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 1202	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 Sept 1953 , to May 6, 1954 , that I last saw the deceased alive on May 6, 1954 , and that death occurred at 2:07 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Blenn M. Salyer M.D.		23b. ADDRESS Cassville Mo.	
23c. DATE SIGNED 5/10/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-9-1954	
24c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		24d. LOCATION (City, town, or county) (State) Exeter, Missouri	
DATE REC'D BY LOCAL REG. 5-13-1954		REGISTRAR'S SIGNATURE Graue Williams	
25. FUNERAL DIRECTOR'S SIGNATURE Blenn M. Salyer		ADDRESS Cassville, Mo.	

BARRY COUNTY HEALTH UNIT
CASSVILLE, MO.

NO. 554-34

DATE REC. 5-15-54

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.

Student Embalmer No.

Signed.....
Student Embalmer

Signed. E. O. J. [Signature]

Licensed Embalmer No. 4817

P. O. Address Cassville, 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.