

FILED OCT 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33175**
Registrar's No. **523**

BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL, and give township) Paplar Bluff	c. LENGTH OF STAY (In this place) 84 years	c. CITY (If outside corporate limits, write RURAL and give township) Paplar Bluff Mo. 0124	
d. FULL NAME OF HOSPITAL OR INSTITUTION Paplar Bluff Hospital		d. STREET ADDRESS (If rural, give location) 920 Adams	

3. NAME OF DECEASED (Type or Print) SARAH. SAYLORS. MOORE.	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Oct 17 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Aug 6. 1870	9. AGE (In years last birthday) Months Days Hours Mins. 84 2 11
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farm wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Wayne Co Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Saylor	13b. MOTHER'S MAIDEN NAME Lucinda Saylor	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Verna Kelley Hamerhille Mo	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis Systemic 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"/>
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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) 4201
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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?
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22. I hereby certify that I attended the deceased from **10-15**, 19**54**, to **10-17**, 19**54**, that I last saw the deceased alive on **10-17**, 19**54**, and that death occurred at **8:40 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE John Hamerhille	(Degree or title) MD	23b. ADDRESS Paplar Bluff Mo	23c. DATE SIGNED 10-19-54
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10/19/1954	24c. NAME OF CEMETERY OR CREMATORY Mount Zion	24d. LOCATION (City, town, or county) (State) Paplar Bluff Mo
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DATE REC'D BY LOCAL REG 10/19/54	REGISTRAR'S SIGNATURE W. H. Minter	439	25. FUNERAL DIRECTOR'S SIGNATURE Constance E. Jones	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
OCT 25 1954
BUTLER CO. HEALTH CENTER
FILE No. _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

W. T. Cameron

Licensed Embalmer No. 342

P. O. Address *Jamesboro Pa.*

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.