

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025725

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 339

**FILED JUL 24 1961**

1. PLACE OF DEATH a. COUNTY <u>JASPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JASPER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>JOPLIN</u>		Length of stay in lb <u>2 1/2 HRS.</u>	c. CITY OR TOWN <u>SARCOXIE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JOPLIN GENERAL HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>SARCOXIE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>LYNN FRANKLIN SALYER</u>			4. DATE OF DEATH Month Day Year <u>JULY 15, 1961</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-20</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE FACTORY</u>	11. BIRTHPLACE (City and state or country) <u>SARCOXIE, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>VERNIE SALYER</u>	13b. MOTHER'S MAIDEN NAME <u>CYNTHIA McCRAKEN</u>	14. NAME OF HUSBAND OR WIFE <u>LORAIN SALYER</u>
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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) <u>YES W.W.#2</u>	17. INFORMANT <u>MRS. LORAIN SALYER, SARCOXIE, MO.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>ACUTE CIRCULATORY FAILURE</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MASSIVE MYOCARDIAL INFARCTION</u>	<u>3 hours</u>
	DUE TO (c) <u>CORONARY OCCLUSION</u>	<u>3 hours</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Oct. 23, 1954 to JULY 15, 61 and last saw her alive on JULY 15, 1961  
Death occurred at 7:25 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <u>D. O.</u>	22b. ADDRESS <u>SARCOXIE, MO.</u>	22c. DATE SIGNED <u>7-16-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7/17/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SARCOXIE CEM.</u>	23d. LOCATION (City, town, or county) <u>SARCOXIE, MO.</u>
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24. FUNERAL DIRECTOR <u>ELMER-MOSS FUNERAL HOME, SARCOXIE, MO.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-21-1961</u>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

JUL 25 1961

SEP 29 1961

AUG 25 1961

**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 \_\_\_\_\_

Signature of Student Embalmer

Signed Melvin C. Lavett

Licensed Embalmer No. 5131

P. O. Address Carthage, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.