

Registration District No. **FILED MAY 10 1946**

Primary Registration District No. **4300**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **McDonald**
 (b) City or town **Goodman, Mo.**
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME **BERTHA JANE SAYLOR**

8. (b) If veteran, name war **L** 8. (c) Social Security No. **✓**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **Clyde SAYLOR** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **March 28 - 1878**
 (Month) (Day) (Year)

AGE:	Years	Months	Days	If less than one day
	68		29	hr. min.

9. Birthplace _____
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **✓**

12. Name **John LYONS**

13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

14. Maiden name **JENNIE JOHNSON**

15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Engelbert Reichardt**

(b) Address **Goodman, Mo.**

17. (a) **Revised** (b) Date thereof **4-28-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ottumwa, Iowa**

18. (a) Signature of funeral director **Chas. W. Williams**

(b) Address **Goodman, Mo.**

19. (a) **May 3, 1946** (b) **Mrs. Fred W. Smith**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **McDonald**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **RFD #2 - Goodman Mo.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? **Born in Mo. years.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **27th**
 year **1946** hour **5** minute **55 M.**

21. I hereby certify that I attended the deceased from **4-24**, 19**46** to **4-27**, 19**46**
 that I last saw her alive on **4-26**, 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Arterial sclerosis.**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy **GA**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
 (e) Means of injury **○**

28. Signature **Paul C Davis** (M. D. or other) **MD.**
 Address **Neosho, Mo.** Date signed **4/27/46**

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Mariellen Williams Pickett*
Licensed Embalmer No. *4166*
P. O. Address *London, 0776*

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, above space should be left blank.