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FILED MAR 30 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9820

BIRTH NO. 127 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <b>St Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St Francois</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Bonne Terre</b>		c. LENGTH OF STAY (In this place) <b>8 hrs</b>	c. CITY OR TOWN <b>Farmington</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bonne Terre Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <b>0940</b>			

3. NAME OF DECEASED (Type or Print) <b>Dennis Leon Saylor</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>March 18 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White US</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>March 18, 1954</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins. <b>8</b>
10a. USUAL OCCUPATION		11. BIRTHPLACE (City and State or Foreign Country) <b>Bonne Terre, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Earl L. Saylor</b>	13b. MOTHER'S MAIDEN NAME <b>Carol Alice Jones</b>	14. NAME OF HUSBAND OR WIFE <b>--</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Earl L. Saylor, Farmington, Mo</b>
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, asthma, etc. It means the disease, injury, or complication which caused death.		17. ADDRESS

18. CAUSE OF DEATH		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>Birth</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Anoxia &amp; Respiratory Failure</b>		DUE TO (b) <b>Cord compression by multiple coil ing over shoulder &amp; around neck in breech presentation</b>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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	19. AGE		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <b>→ 10<sup>30</sup> A.M. (delivery)</b>

22. I hereby certify that I attended the deceased from **3-18**, 19**54**, to **3-18**, 19**54** that I last saw the deceased alive on **3-18**, 19**54**, and that death occurred at **6 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>F. Richard Couch M.D.</b>	(Degree or title)	23b. ADDRESS <b>301 W. Liberty St., Farmington, Mo.</b>	23c. DATE SIGNED <b>3-19-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>3/19/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Three Rivers Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Farmington Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Mar. 19 1954</b>	REGISTRAR'S SIGNATURE <b>Esther Redloff</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Miller Funeral Home Farmington, Mo.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 not embalmed, Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Bull Dogal

Licensed Embalmer No. 4120

P. O. Address Farmington

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.