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.

REC'D APR 12 1939

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

8297
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 2062
or
(c) City ..... (d) Street No. Firmin Desloge Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Oliver Sallee
(a) Residence, No. 2748 N. Prairie Ave St. 11
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Rosemary
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug., 25, 1901
7. AGE: YEARS 37 MONTHS 6 DAYS 7 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Chauffeur
9. Industry or business in which work was done, as saw mill, bank, etc. Polar Wave Ice &
10. Date deceased last worked at this occupation (month and year) Coal
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis, Mo.

FATHER
13. NAME: Lee Sallee
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

MOTHER
15. MAIDEN NAME: Anna E. Mathias
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): Mrs. Rosemary Sallee, 2748 N. Prairie Ave
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Mt. Olive Cem. DATE: 3-4-39, 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Drehmann-Harral, 1905 N. Union Blvd.
20. FILED MAR 8 1939 J. F. Budeck Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 3/2/39, 19

22. I HEREBY CERTIFY, That I attended deceased from 12/28/39, 19, to 3/2/39, 19
I last saw him alive on 3/1/, 1939. Death is said to have occurred on the date stated above, at 9:20a.m.
The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Chronic glomerular nephritis (nephrosclerosis) | Uncertain |
| Hypertensive cardio-vascular disease | Uncertain |

Other contributory causes of importance:

Name of operation: Phys. & Lab. Date of
What test confirmed diagnosis? Exam. Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: NO
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) G. D. Brown, M. D.
(Address) 1325 S. Grand Blvd.,

(Licensed Embalmer's Statement on Reverse Side)

## 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 Warren A. Carver

Licensed Embalmer No. 353K

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**