No. 2
11-10-39
-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20863

Registration District No. FILED JUL 15 1940

Primary Registration District No. 1002

Registrar's No. 2480

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
At Home (2816 Nickolson) ?
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community 36 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Missouri
(If outside city or town limits write "RURAL")

(d) Street No. 2816 Nickolson St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William Sallee 4-07

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Catherine Sallee

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased August (Month) 12 (Day) 1866 (Year)

8. AGE: Years 73½ Months 10 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Water Dept. (Laborer)

11. Industry or business M. O. R. Water Dept.

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

16. (a) Informant Mrs. Catherin Sallee
(b) Address 2816 Nickolson St. K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 40 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Rose & Henderson
(b) Address 15th & Jackson St. K.C. Mo

19. (a) June 17, 1940 (Date received local registrar) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from May 1938, 19__, to June 15, 1940, that I last saw him alive on June 15, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Valvular insufficiency	2 yr
Due to Chronic Myocarditis	2 yr
Due to Bronchiectasis (A.L.)	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy —	

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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)
While at work? — (e) Means of injury? —

23. Signature Earl V. Jones (M. D. or other) P.O
Address 100½ S. Osage Date signed 6-17-40

(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.....

Licensed Embalmer No. 296-5

P. O. Address K. C. Mo

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

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