

FILED MAR 2 1945

Registration District No. 11

Primary Registration District No. 4023

Registrar's No. 6

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

1. PLACE OF DEATH:

(a) County Barry

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

(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community life years, months or days

3. (a) PRINT FULL NAME Ernest Sallee

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Sue Sallee 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased June 2 1871  
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Barry Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Mail Carrier

11. Industry or business \_\_\_\_\_

12. Name Thos. Sallee

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

14. Maiden name Nancy Hale

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

16. (a) Informant Mrs. Sue Sallee

(b) Address Pierce City, Mo.

17. (a) burial (b) Date thereof 1/31/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Exeter Mo. Cem.

18. (c) Signature of funeral director W. H. Koon  
Cassville, Mo.

(b) Address \_\_\_\_\_

19. (a) Feb 2-1945 (b) Grace Williams  
Date received local registrar (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Barry

(c) City or town Exeter  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29  
year 1945 hour 11 minute 10 A. M.

21. I hereby certify that I attended the deceased from Jan 15 to Jan 29 1945; that I last saw him alive on Jan 5 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure Duration 2 mo

Due to Chronic nephritis 4 yrs

Due to Vascular Hypertension 4 yrs

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) \_\_\_\_\_

(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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature Robert Glynn (M. D. or other) \_\_\_\_\_  
Address Springfield Date signed 1/31/45

RECEIVED

District Health Officer No. 6,

District File Number 245-234

Date Filed FEB 28 1945

MAR 20 1945

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 *E. M. Janner*

Licensed Embalmer No. 3453

P. O. Address Cassville, 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 this body is not embalmed, fact should be so stated above.