

No. 2  
-5-43  
5-17-47  
X3667

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27089**  
Registrar's No. **19**

Registration District No. **68**

Primary Registration District No. **5266**

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

1. PLACE OF DEATH:

(a) County **Christian**  
(b) City or town **Ozark Mo. Rural**  
(c) Name of hospital or institution: **Linley Township**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: **25 years** (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Christian**  
(c) City or town **Ozark Mo. Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Rural**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

**Salla H. Stine**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **F**

5. Color or race **W.**

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

6. (b) Name of husband or wife **W. O. Stine**

6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Dec 7 - 1870**  
(Month) (Day) (Year)

8. AGE:

Years **76** Months **5** Days **8**  
If less than one day hr. min.

9. Birthplace

**Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation

**Home wife**

11. Industry or business

MOTHER FATHER  
12. Name **S. M. Keltner**  
13. Birthplace **Tenn**  
14. Maiden name **Mary Gordon**  
15. Birthplace **Tenn**

16. (a) Informant **W. O. Stine**  
(b) Address **Ozark Mo. Rural**  
17. (a) **Burial** (b) Date thereof **May 17-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Richmond Cemetery**  
18. (a) Signature of funeral director **T. B. Chaffin**  
(b) Address **Ozark Mo**  
19. (a) **June 30 1947** (b) **Luella M. Leonard**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **15** year **1947** hour **7:18** minute **10<sup>00</sup>** A.M.  
21. I hereby certify that I attended the deceased from **13 May**, 19**47** to **15 May**, 19**47**  
that I last saw her alive on **14 May**, 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction heart disease**

Duration **unknown**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

**93B**

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 **S. D. Rom** (M. D. or other) **MD**  
Address **Ozark, Mo** Date signed **16 May 47**

RECEIVED  
District Health Officer No. 6,  
District File Number 847-940  
Date Filed AUG 27 1953

DEC 22 1953

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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 T. B. Chaffin  
Licensed Embalmer No. 2192  
P. O. Address Ozark 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.**