

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43367

State File No.

FILED DEC 27 1950

BIRTH NO. _____ REG. DIST. NO. 356 PRIMARY REG. DIST. NO. 6209 Registrar's No. 42

070

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

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Tx.</u> b. COUNTY <u>Texas</u>	
b. CITY OR TOWN <u>Rural Carey</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Carey</u>	
c. LENGTH OF STAY (in this place) <u>2 yrs.</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>OLIVER</u>	b. (Middle) <u>Llewellyn</u>	c. (Last) <u>Sallee</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11 30 50</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 23, 1879</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 4 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Roubidoux Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A</u>
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13a. FATHER'S NAME <u>William Sallee</u>	13b. MOTHER'S MAIDEN NAME <u>Frances McWhorter</u>	14. NAME OF HUSBAND OR WIFE <u>Uiolet</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT'S SIGNATURE OR NAME <u>Uiolet Sallee</u>	ADDRESS <u>Houston, Mo.</u>
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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, asthenia; etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>153X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Transverse Colon & metastases secondary to liver</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Secondary anemia +</u> DUE TO (c) <u>Malnutrition (severe)</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>			

19a. DATE OF OPERATION <u>10/10/50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Primary Carcinoma of Transverse Colon with metastases to liver</u>	19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u></u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u></u>
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22. I hereby certify that I attended the deceased from Feb. 2, 1948, to 11/29, 1950, that I last saw the deceased alive on 11/29, 1950, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>J. Burns, MD</u>	(Degree or title)	23b. ADDRESS <u>Houston, Mo</u>	23c. DATE SIGNED <u>12/2/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-2-50</u>	24c. NAME OF CEMETERY OR GREGATORY <u>Houston</u>	24d. LOCATION (City, town, or county) (State) <u>Houston Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Dec. 18. 50</u>	REGISTRAR'S SIGNATURE <u>Myrtle Craig</u>	327	25. FUNERAL DIRECTOR'S SIGNATURE <u>Dwight D. Elliott</u>	ADDRESS <u>Houston, Mo.</u>
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DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED

DEC 20 1950

Dist. File

1250-2544

Date Filed

12-21-50

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

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.