

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38641**

S. No. 300
V. 10.48

FILED NOV 19 1953

REG. DIST. NO. **96** PRIMARY REG. DIST. NO. **5354** Registrar's No. **65**

3200

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

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dallas	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fair Grove (Sheridan)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fair Grove Sheridan Twp	
c. LENGTH OF STAY (In this place) 20 yrs.		d. STREET ADDRESS (If rural, give location) 6 miles N.E. Fair Grove	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6 miles N.E. Fair Grove		d. STREET ADDRESS (If rural, give location) 6 miles N.E. Fair Grove	
3. NAME OF DECEASED a. (First) Lula b. (Middle) Augusta c. (Last) Sallee			4. DATE OF DEATH (Month) (Day) (Year) Nov 5 1953
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 2 1879
9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10a. KIND OF BUSINESS OR INDUSTRY House Work	11. BIRTHPLACE (City and State or Foreign Country) Greene Co Mo
12. CITIZEN OF WHAT COUNTRY? USA	13a. FATHER'S NAME John Alexander	13b. MOTHER'S MAIDEN NAME Charity Oline	14. NAME OF HUSBAND OR WIFE Ebram Sallee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ebram Sallee Fair Grove Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Valvular Heart dis & decompensation ANTECEDENT CAUSES DUE TO (b) Arterio Sclerosis DUE TO (c) Opium abuse? II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal pneumonia	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 6 Mo	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 5, 1953 , to _____, 19____, that I last saw the deceased alive on Nov 5, 1953 , and that death occurred at 12:57 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) G. B. Phummer M.D.		23b. ADDRESS Buffalo Mo	23c. DATE SIGNED 11-7-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 9 / 53	24c. NAME OF CEMETERY OR CREMATORY Pleasant View	24d. LOCATION (City, town, or county) (State) Near Elkland Mo
DATE REC'D BY LOCAL REG. 11/16/53	REGISTRAR'S SIGNATURE Mrs. Grace Peters	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Erwid + Blue Bolivar Mo	

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

Richard B. Erwin

Licensed Embalmer No. 3092

P. O. Address Bolivar, 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.