

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **15014**

No. 300
10.48
FILED MAY 18 1954

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **477**

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph c. LENGTH OF STAY (in this place) Life d. FULL NAME OF HOSPITAL OR INSTITUTION 2512 So. 3rd St.,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph d. STREET ADDRESS (If rural, give location) 2512 So. 3rd St.,	
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3. NAME OF DECEASED (Type or Print) a. (First) TACY b. (Middle) A. c. (Last) SALES	4. DATE OF DEATH (Month) (Day) (Year) 5/4/1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7/26/1880	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR (Specify) 9	IF UNDER 24 HRS. (Specify) 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Homemaking	11. BIRTHPLACE (State or foreign country) Elwood, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wm. G. Hayes Armedina Parker	13b. MOTHER'S MAIDEN NAME Armedina Parker Wm. G. Hayes	14. NAME OF HUSBAND OR WIFE Wm Sales
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Wm Sales	ADDRESS 2512 S. 3rd St.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Arteriosclerotic Heart Disease & Decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	INTERVAL BETWEEN ONSET AND DEATH 3 mo. 4200
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 1957, to May 4, 1957, that I last saw the deceased alive on May 1, 1957 and that death occurred at 5:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>J. J. Pherrillins M.D.</i>	23b. ADDRESS Doctors Bldg. City	23c. DATE SIGNED 5-7-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 6, 1954	24c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. May 11, 1954	REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i>	485-	25. FUNERAL DIRECTOR'S SIGNATURE <i>Clark</i>	ADDRESS Clark Funeral Home St. Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Emm a Clark*

Licensed Embalmer No. 41238

P. O. Address *M. G. ...*

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.