

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-016256

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2384 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1
2 61472
3
4 3
5 2
6
7 0
8 2
9 153.8
10
11
12 900
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

P. C. Turner

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Callaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in lb 9 Mom.	c. CITY OR TOWN Fulton, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2334 Walrond		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 819 State Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Elnora Middle Sallee Last Sallee		4. DATE OF DEATH Month 4 Day 20 Year 63	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-14-75
9. AGE (last birthday) 88		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (City and state or country) Callaway Co., Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Charlæe Richmond	
13b. MOTHER'S MAIDEN NAME Mariara-----		14. NAME OF HUSBAND OR WIFE Warren Sallee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Dorothy Fields 2334 Walrond		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure			INTERVAL BETWEEN ONSET AND DEATH 7 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Intestinal Obstruction			
DUE TO (c) Possible Cancer of Colon			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 4-15-63 to 4-20-63 and last saw her alive on 4-20-63 Death occurred at 8:55 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>[Signature]</i>		22b. ADDRESS 1433 E. 19th St., K. C. Mo	22c. DATE SIGNED 4-22-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-21-63	23c. NAME OF CEMETERY OR CREMATORY White Cloud Cemetery	23d. LOCATION (City, town, or county) Fulton, Mo.
24. FUNERAL DIRECTOR Jones & Stevens		ADDRESS K. C. Mo.	25. DATE RECD. BY LOCAL REG. 4-22-63
		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE BLACK INK OR TYPEWRITER RIBBON

27410
X
W
R
O
R

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 _____

Signature of 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

070