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15722

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED APR 28 1942

Registration District No. 797

Primary Registration District No. 1060

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Saline

(a) County: Saline

(b) City or town: Rural, Miami  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 55 years (Specify whether years, months or days)

In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Saline 97

(c) City or town: Rural, Miami. 0  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME: Mrs. Sallie Ann Page

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: George 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: May 10, 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>11</u>	<u>7</u>	_____ hr. _____ min.

9. Birthplace: Saline MO (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife (City, town, or county) (State or foreign country)

11. Industry or business: Farm

12. Name: James E. Butler

13. Birthplace: London England (City, town, or county) (State or foreign country)

14. Maiden name: \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace: Va (City, town, or county) (State or foreign country)

16. (a) Informant: Roy Page

(b) Address: Slater MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: APRIL, 19, 42 (Month) (Day) (Year)

(c) Place: burial or cremation: Slater Mo

18. (a) Signature of funeral director: Jones and Salzer

(b) Address: Slater MO.

19. (a) \_\_\_\_\_ (Date received local registrar) (b) Mr. John Giger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17 year 1942 hour 7 minute 0 M.

21. I hereby certify that I attended the deceased from held inquest April 17, 1942 19\_\_\_\_; that I last saw h. alive on 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Suicide

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): Suicide

(b) Date of occurrence: April 17, 1942

(c) Where did injury occur? at home in closet (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? l (Specify type of place) (e) Means of injury: Saline Co

23. Signature: P. L. Lawless Coroner (M. D. or other) Saline Co

Address: Marshall Mo Date signed: 4/17/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

19  
0  
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RECEIVED

APR 30 1942

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 4-27-42

**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

*Herman Dolzer*

Licensed Embalmer No. 1831

P. O. Address

*Slater*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15722

Registration District No. 797

Primary Registration District No. 6040

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Sally A Page  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 10 1887  
(Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) Apr 20 42 (b) Mrs. John Giger  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Apr day \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
that I last saw him/her alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to suicide hanging in closet at her home  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

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

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) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

1947  
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