

FILED NOV 13 1944

Registration District No. 517

Primary Registration District No. 6076

1. PLACE OF DEATH:
 (a) County ST. Louis
 (b) City or town CITY OF ST. LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4539 Ray Avenue
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town city of St. Louis 17
 (d) Street No. 4539 Ray Avenue 9
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mary Sallee
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife O.L. Sallee
 6. (c) Age of husband or wife if alive 1 years
 7. Birth date of deceased January 1 1871
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 10 2 hr. min.

9. Birthplace St. Louis Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation housework

11. Industry or business at home

MOTHER FATHER
 12. Name Michael Callahan
 13. Birthplace Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Lacy
 15. Birthplace Ireland
 (City, town, or county) (State or foreign country)

16. (a) Informant O. J. Sallee
 (b) Address 4539 Ray Avenue

17. (a) burial (b) Date thereof Nov 6 '44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mount Olive Cemetery

18. (a) Signature of funeral director Southern Funeral Home
 (b) Address 6322 South Grand Blvd.

19. (a) NOV 7 1944 (b) E. J. Melhuran N.D.
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month November Day 3rd
 year 1944 hour 5:00 minute a. M.
 21. I hereby certify that I attended the deceased from July 9
1944 to Nov 3 1944;
 that I last saw her alive on Nov 2, 1944;
 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction
hypertension
 Duration _____

Due to arteriosclerosis

Due to 97

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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? _____

(Specify type of place)
 While at work? _____ (c) Means of injury _____

23. Signature A. J. Nerkin (M. D. or other)
 Address 3507 Colony Date signed 11-5-44

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

Dr. Markuslin
4627 Taylor

Je. 2110
12:30 to 4:00 Fri.

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 Virgil L. Berryman

Licensed Embalmer No. 4018

P. O. Address St. Louis, 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.

Registration District No. 317

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
#639-Ray Ave
Manchester, Mo
(If not in hospital or institution, give street number or location)

(d) Length of stay: in hospital or institution home
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Mary Sallee

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan (Month) / 1 (Day) / 1944 (Year)

8. AGE: Years 73 Months 10 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) E. J. McElvran, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4539 Ray Ave
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

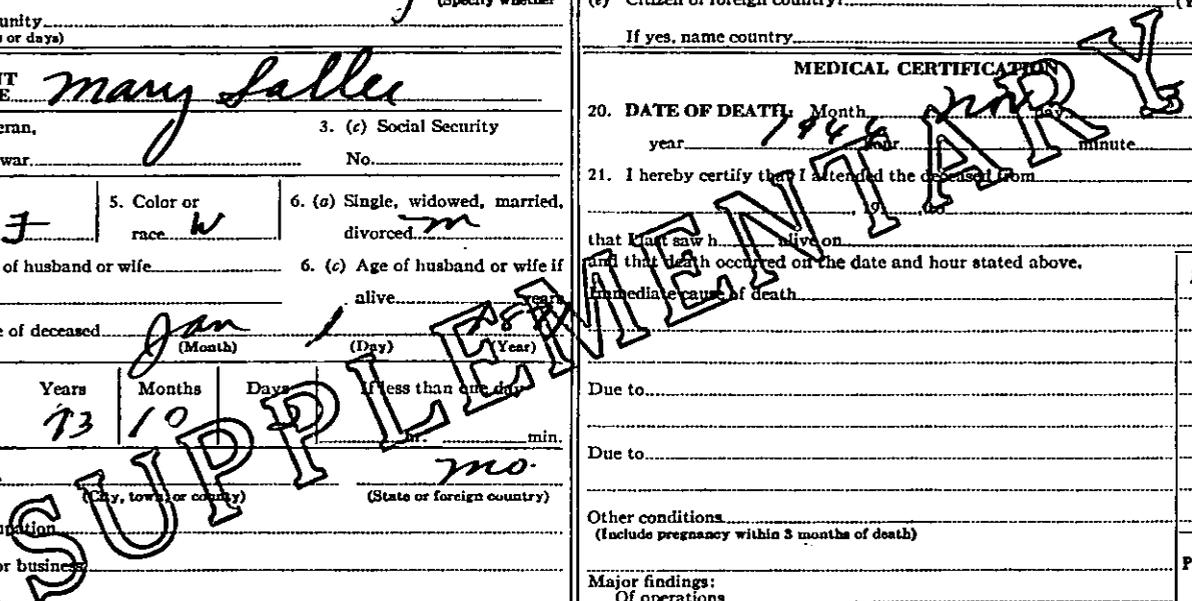
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____



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