

S. No. 2
M-243
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State Filed No. **41784**

FILED JAN 26 1945

Primary Registration District No. **6292**

Registrar's No. **33**

1. PLACE OF DEATH:
 (a) County **Ozark**
 (b) City or town **Pondfork Thornfield**
 (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) **1**
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Douglas** **34**
 (c) City or town **Pondfork**
 (If outside city or town limits, write "RURAL") **0**
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Mary E. Sallee**
 3. (b) If veteran, name war _____ 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 **James B. Sallee** 6. (c) Age of husband or wife if alive **63** years
 7. Birth date of deceased **March 18, 1880**
 (Month) (Day) (Year)

8. AGE: Years **63** Months **9** Days **15** If less than one day _____ hr. _____ min.

9. Birthplace **Fairfield, Iowa**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
 12. Name **Thomas N. Hobbs**
 13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Martha E. Cox**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Clarence Sallee**
 (b) Address **Longview, Mo.**

17. (a) **Burial** (b) Date thereof **1-5-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Thornfield**

18. (a) Signature of funeral director **Clinkingbeard Funeral Home**
Ava, Missouri
 (b) Address _____

19. (a) **12-20-44** (b) **Margaret Hutchison**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Jan.** day **3**
 year **1944** hour **6** minute **12 P.M.**
 21. I hereby certify that I attended the deceased from **Jan 3** 19**44**
 that I last saw **her** alive on **1-3-44**
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Acute Cerebral Apoplexy Duration **6 hrs**
Acute Hypertension **3 1/2**
Chronic Myocarditis **?**

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations **97d**
 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 **5**
 23. Signature **M. C. Gentry** (M. D. or other)
 Address **Ava, Mo** Date signed **1-7-44**

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

Dr. M. C. Gentry

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 W. B. Hutchins

Licensed Embalmer No. 3431

P. O. Address W. B. Hutchins

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.