

2
-43
-39
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 26 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1414
State File No. 179
Registrar's No.

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **3304 Wyoming St.**
(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 **Kansas** (b) County **Wyandotte**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3305 Cissna St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Robert Salley

3. (b) If veteran name war _____ No. **none**
3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Child**

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

7. Birth date of deceased **July 12 1929**
(Month) (Day) (Year)

8. AGE: Years **15** Months **5** Days **29**
If less than one day hr. min.

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

10. Usual occupation **Student**

11. Industry or business _____

MOTHER: 12. Name **William T. Salley**

13. Birthplace **Springfield Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Oma Appleby**

15. Birthplace **Springfield Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm J Salley**

(b) Address **3005 Cissna St. KANS. City, Ks.**

17. (a) **Burial** (b) Date thereof **1-13-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Pk. K.C.K.**

18. (a) Signature of funeral director **Eds. Brostman Home**
(b) Address **1416 Minn Ave. Kansas City, Ks.**

19. (a) **1-12-45** (b) **H. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **11**
year **1945** hour **10:20** minute **A** M.

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

Immediate cause of death **Fractured Skull**

Due to **automobile Traumatism**

Due to **car hit a post**

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

Major findings: **1706-8**
Of operations **Autopsy & Impression 57**
Of autopsy **no**

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) **accident 123**

(b) Date of occurrence **1-11-45**

(c) Where did injury occur? **3208 Quarta K.C. public place**
(City or town) (County) (State)

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

While at work? **no** (Specify type of place)
(e) Means of injury **auto**

23. Signature **J. E. Brown** (M, D. or other)
Address **1424 1/2 W. 11th St.** Date signed **1-11-45**

WRITE PLAINLY—USE 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~~ by.....

Francis Walton....., Registered Apprentice No. *2744*
working under my personal supervision.

Signed.....

J. H. Pappas
.....
Licensed Embalmer No. *2744*

P. O. Address *K. E. 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.