

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

Registration District No. 1 Primary Registration District No. 5004

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Nineveh Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None -- Nineveh Twp.
(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 Adair
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Nineveh Twp.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles William Sallade
3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 7th year 1948 hour 3 minute 30 P.M.
21. I hereby certify that I attended the deceased from April 27 1948 to Aug 7 1948 that I last saw him alive on Aug 7 1948 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Fern Sallade
6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased: March 19 1948
(Month) (Day) (Year)

Immediate cause of death Coronary occlusion
Duration _____
Due to _____
Due to _____

8. AGE: Years 41 Months 4 Days 19
If less than one day _____ hr. _____ min.

Other conditions Ulcerative Colitis
(Include pregnancy within 3 months of death)

9. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

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

MOTHER FATHER
11. Industry or business Farm
12. Name James Sallade
13. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Lillie Hendrix
15. Birthplace Adair Co. Missouri
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Ester Conner Wandell
(b) Address 1307 So Baird, Parkville
17. (a) Burial (b) Date thereof Aug. 10, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(Specify type of place)
While at work? _____ (b) Means of injury _____
23. Signature J. T. Rhoads (M.D. or other) 200
Address Parkville Mo Date signed 8-9-48

(c) Place: burial or cremation Shibleys Point Cem.
18. (a) Signature of funeral director Glenn E. Hunt, Sr.
(b) Address Green City, Missouri
19. (a) 8-13-48 (b) Wate Lambert
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 10

District File Number B-48-14

Date Filed AUG 17 1948

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.