

FILED MAR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7274

BIRTH NO. _____		REG. DIST. NO. 1		PRIMARY REG. DIST. NO. 5004		Registrar's No. 86			
1. PLACE OF DEATH a. COUNTY ADAIR				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY ADAIR					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - NINEVEH TWP.		c. LENGTH OF STAY (in this place) LIFE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - NINEVEH TWP.		0			
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME IN NINEVEH TWP. ADAIR CO.				d. STREET ADDRESS (If rural, give location) R.F.D. STAHL, MO.					
3. NAME OF DECEASED (Type or Print) a. (First) RUTH		b. (Middle) FERN		c. (Last) SALLADE		4. DATE OF DEATH (Month) (Day) (Year) MARCH 22, 1949			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH OCTOBER 19, 1909	9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 1 YEAR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 1 YEAR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13a. FATHER'S NAME CLARENCE JOHNSON			13b. MOTHER'S MAIDEN NAME ABIS O'BRIAN		14. NAME OF HUSBAND OR WIFE WILLIAM SALLADE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME James W. Sallade, Stahl, Mo. ADDRESS Stahl, Mo.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
I. DISEASE OR CONDITION, DIRECTLY LEADING TO DEATH* (a) Angina Pectoris				ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____					
DUE TO (c) _____				II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.				1-20					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:15 m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Robert B. Wanic, Coronator				23b. ADDRESS Keokville, Mo.		23c. DATE SIGNED 3-23-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 26, 49	24c. NAME OF CEMETERY OR CREMATORY Shelley's Point Cem.		24d. LOCATION (City, town, or county) (State) Adair Co. Mo.				
DATE REC'D BY LOCAL REG. 4-1-49		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE Glenn E. Kent & Son ADDRESS Brunswick, Mo.					

45 (Licensed Embalmer's Statement on Reverse Side)

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

APR 7 1949

RECEIVED

District Health Officer No.

District File Number 349

Date Filed MAR 29 1949

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

Karl R. Kent

Student Embalmer No. 243

working under my personal supervision.

Signed *Karl R. Kent*
Student Embalmer

Signed *Archie W. Wade*

Licensed Embalmer No. 3037

P. O. Address *Brewster*

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.