

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35815**
Registrar's No. **238**

FILED NOV 3 1952

BIRTH NO. _____ REG. DIST. NO. **251** PRIMARY REG. DIST. NO. **4370**

17404

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

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE IOWA b. COUNTY Page	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clearmont		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Coin	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wallen Rest Home		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Celeste b. (Middle) Eldora c. (Last) Sallee		4. DATE OF DEATH (Month) (Day) (Year) Oct-- 21-1952	
5. SEX Female	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb-25-1859
9. AGE (In years less birthday) 93		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Iowa
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gen House work	12. CITIZEN OF WHAT COUNTRY? U S
13a. FATHER'S NAME Benjamin Micheal		13b. MOTHER'S MAIDEN NAME Elizabeth Gibson	14. NAME OF HUSBAND OR WIFE Robert Sallee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Burdette Sallee ADDRESS Coin, Iowa
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral-arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 yrs. ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 334X	
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 Jan 9, 1951 , to Oct 20, 1952 , that I last saw the deceased alive on Oct 18, 1952 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Lawrence Ford M.D. (Degree or title)		23b. ADDRESS Coin, Mo.	
23c. DATE SIGNED Oct 21 1952			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct-23-1952	
24c. NAME OF CEMETERY OR CREMATORY Blanchard		24d. LOCATION (City, town, or county) (State) Blanchard, Iowa	
DATE REC'D BY LOCAL REG. 11-1-52		REGISTRAR'S SIGNATURE Bess Holt 229	
25. FUNERAL DIRECTOR'S SIGNATURE Westboro, Mo			

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.....

~~#####~~ ~~##~~ A R Tucker #2

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed



Licensed Embalmer No. 4757

P. O. Address Westboro, Missouri

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.