

FILED OCT 25 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33632

State File No.

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 969

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene							
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Springfield)		c. LENGTH OF STAY (in this place) township)		c. CITY OR TOWN Springfield		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION 2651 N. Kellett				STREET ADDRESS (If rural, give location) 2651 N. Kellett 0346							
3. NAME OF DECEASED (Type or Print) a. (First) ZELLA		b. (Middle)		c. (Last) SALLEE		4. DATE OF DEATH (Month) (Day) (Year) October 19, 1954					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 17 Aug. 1895					
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY In Home		11. BIRTHPLACE (City and State or Foreign Country) Pleasant Hope, Mo.					
12. CITIZEN OF WHAT COUNTRY? USA				13a. FATHER'S NAME Jeff Choate		13b. MOTHER'S MAIDEN NAME (?) Smith					
14. NAME OF HUSBAND OR WIFE O.R. Sallee Springfield, Mo				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. Unknown				17. INFORMANT'S SIGNATURE OR NAME ADDRESS O.R. Sallee Springfield, 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION: I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Adenocarcinoma of endometrium of uterus with metastases 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.				INTERVAL BETWEEN ONSET AND DEATH examined on 8 July 54 - fruit			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		174X					
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) m.		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 6 March, 1950 , to 19 Oct , 19 54 , that I last saw the deceased alive on 24 Sept , 19 54 , and that death occurred at 11:15A. , from the causes and on the date stated above.											
23a. SIGNATURE Henry F. Knabb, Jr. M.D.		(Degree or title)		23b. ADDRESS 1630 N. Jefferson Springfield, Missouri		23c. DATE SIGNED 10-20-54					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-21-54		24c. NAME OF CEMETERY OR CREMATORY Rock Prairie Cemetery		24d. LOCATION (City, town, or county) (State) Dallas County Missouri					
DATE REC'D BY LOCAL REG. 10-20-54		REGISTRAR'S SIGNATURE Edith Williams		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Klingner + Co. Springfield, Mo.							

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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, or by Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Max Anderson*.....

Licensed Embalmer No. *407*.....

P. O. Address *Springfield*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.