

Dept. Health,
ic., & Welfare
S. Public
Health Service

FILED DEC 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40064

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 17

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rural Trail Creek Exp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nell Mem.</u>		Length of stay in lb <u>4 days</u>	d. STREET ADDRESS (If outside, give location) <u>1 Mile S. Mt Moriah</u>

3. NAME OF DECEASED (Type or print) First <u>Rhue</u> Middle <u>Ann</u> Last <u>Sallee</u>			4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-1984</u>	9. AGE (In years last birthday) <u>7-3</u>	FUNDER 1 YEAR Months <u>6</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Harrison County Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>James A. Woodruff</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine Stotts</u>	14. NAME OF HUSBAND OR WIFE <u>Oliver Sallee</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Helen Eberole</u> Address <u>Bethany Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANTERIOR & POSTERIOR MYOCARDIAL INFARCT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CORONARY THROMBOSIS</u>	<u>6 days.</u>
	DUE TO (c) <u>ARTERIO SCLEROTIC HEART DISEASE.</u>	<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HYPERTENSION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Bethany</u>	COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from Dec. 7, 1957 to Dec. 10, 1957 and last saw ^{her} alive on Dec. 10, 1957
Death occurred at 10:35 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Albert Dubbe M.D.</u> (Degree or title)	22b. ADDRESS <u>Bethany, Mo.</u>	22c. DATE SIGNED <u>12-12-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-13-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mt Moriah Mo.</u>
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24. FUNERAL DIRECTOR <u>W. H. Shaw</u> ADDRESS <u>Bethany Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-14-1957</u>	26. REGISTRAR'S SIGNATURE <u>Jella Massey</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certification in the specific manner required by 193.140 MoRS 1949.

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(Licensed Embalmer's Statement on Reverse Side)

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 *W. B. Jones*

Licensed Embalmer No. *3899*

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