

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED NOV 21 1957

Registration District No. 182

Primary Registration District No. 4296

Registrar's No. 31

Health, & Welfare  
Public  
Service

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Browning</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Browning</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nove Crutcher Saulsbury</b>			4. DATE OF DEATH Month Day Year <b>11 8 57</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 12 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
13a. FATHER'S NAME <b>Dave Saulsbury</b>		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <b>Verna M. Saulsbury</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>446102171</b>	17. INFORMANT Address <b>Verna M Saulsbury Browning, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic myocardial artery sclerosis</b>			<b>years</b>
DUE TO (c) <b>hypertrophy of hypertensive</b>			<b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>443X</b>			(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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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 COUNTY STATE
21. I attended the deceased from <b>11-6-57</b> to <b>11-8-57</b> and last saw <sup>her</sup> him alive on <b>11-8-57</b> Death occurred at <b>1:35P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <b>W. L. Judd Do</b>		22b. ADDRESS <b>Wm. ...</b>	22c. DATE SIGNED <b>11-10-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-11-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Wood Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Milan Mo.</b>
24. FUNERAL DIRECTOR <b>Wade Funeral Home</b>		ADDRESS <b>Browning, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Nov 20 - 1957</b>
26. REGISTRAR'S SIGNATURE <b>Mrs Budie Kelley</b>			

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

MEDICAL CERTIFICATION

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 *Gerald J. Ward* .....

Licensed Embalmer No. *4172* .....

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

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.