

FILED FEB 3 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1417

STATE FILE NUMBER

190

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 190

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3010 Brooklyn		Length of stay in 1b 4 yrs	d. STREET ADDRESS (If outside, give location) 3010 Brooklyn Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Jeff	Middle Baker	Last Sallis	4. DATE OF DEATH Month Jan. Day 10, Year 1958
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5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1906	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	10b. KIND OF BUSINESS OR INDUSTRY cont + suit mfg	11. BIRTHPLACE (City and state or country) Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME William Sallis	13b. MOTHER'S MAIDEN NAME Elizabeth Robbins	14. NAME OF HUSBAND OR WIFE Verlean Sallis
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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. 446-05-9975	17. INFORMANT Parlor Mrs. Maxine Ballard, K.C., Mo.
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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) Acute terminal Penicillin Feb		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) As above	
	DUE TO (c) Poisoning. 70% saturation	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2:30 P.M. 15

20a. ACCIDENT <input checked="" 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.) Poisoning gas heater
20c. TIME OF INJURY Hour 1 Month 10 Day 58 a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION Kansas City, Jackson, Mo.
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21. I attended the deceased from _____, to _____ and last saw her alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Nighon Owens-Carrner	(Degree or title)	22b. ADDRESS 1034 Quattri Bldg	22c. DATE SIGNED 1-11-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/13/58	23c. NAME OF CEMETERY OR CREMATORY —	23d. LOCATION (City, town, or county) (State) Ft. Gibson, Muskogee, O. la.
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24. FUNERAL DIRECTOR Madreau, Appleton & Jones, K.C., Mo.	25. DATE RECD. BY LOCAL REG. 1-13-58	26. REGISTRAR'S SIGNATURE neva Marshall
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
High H. Owens

All diseases in Part I must be causally related.



APR 18 1958

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 *Conrad G. Gady B.*

Licensed Embalmer No. *4944*

P. O. Address *K.C. 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.