

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009936
STATE FILE NUMBER

FILED APR 1 1959

Registration District No. 163 Primary Registration District No. 3031 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN De Soto		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN De Soto c 503 o
c. FULL NAME OF HOSPITAL OR INSTITUTION 718 S. 2nd St.		Length of stay in 1b 14 yrs	d. STREET ADDRESS (If outside, give location) 718 S. 2nd St.
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Jennie Middle NMN Last Salisbury			4. DATE OF DEATH Month March Day 25 Year 1959		
--	--	--	---	--	--

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1884	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 7 Days 26	IF UNDER 24 HRS. Hours 1 Min. 0
--------------------	------------------------------	---	--	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY - - - -	11. BIRTHPLACE (City and state or country) Pikeville, Ky.	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME Joshua Sweeny	13b. MOTHER'S MAIDEN NAME Not known	14. NAME OF HUSBAND OR WIFE Robt. Salisbury
--	---	---

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. - - - -	17. INFORMANT Robt. Salisbury, De Soto, Mo.	Address
--	---	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon, with metastases to liver.			INTERVAL BETWEEN ONSET AND DEATH ? 1 year +
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____		
	DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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 _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION 1538	COUNTY	STATE
---	--	---	--------	-------

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
---	------------------------------	--------	-------

21. I attended the deceased from August, 1958 to March 25, 1959 and last saw her alive on March 22, 1959
Death occurred at 4:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas A. Donnell M.D.	22b. ADDRESS De Soto, Mo.	22c. DATE SIGNED 3-26-59
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, or other (Specify) Burial	23b. DATE 3-28-59	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City, town, or county) (State) De Soto, Jefferson, Mo.
---	-----------------------------	---	---

24. FUNERAL DIRECTOR J. Lee Mothershead, De Soto, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. Mar. 26-1959	26. REGISTRAR'S SIGNATURE Marie Ferris.
---	---------	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

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 *J. E. Mothershead*

Licensed Embalmer No. *3531*
P. O. Address *Delate*

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.