

STATE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028776

FILED 15 SEP 8 1959

CLAYTON
DEED

Registration District No. 728 Primary Registration District No. 2000 Registrar's No. 924

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SHANNON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 9 HRS.		c. CITY OR TOWN WINONA		*Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DENNIS Middle LEE Last SALLEE				4. DATE OF DEATH Month AUG. Day 31 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/31/59	9. AGE (last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days
						Hours 13	Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MT. VIEW, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME CARL SALLEE			13b. MOTHER'S MAIDEN NAME MARY VAUGH			14. NAME OF HUSBAND OR WIFE X	
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. NO		17. INFORMANT Address CARL SALLEE WINONA, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY ATISLECTASIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 9 hrs 9 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 a.m. p.m.		Month, Day, Year					
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 <u>8-31-59</u> to <u>8-31-59</u> and last saw her/him alive on <u>8-31-59</u> Death occurred at <u>6:15 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Edgar L. Clayton MD</i> (Degree or title)				22b. ADDRESS Springfield, Missouri			22c. DATE SIGNED 9-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/2/59	23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION (City, town, or county) WINONA, MO. (State)			
24. FUNERAL DIRECTOR H. H. LOHMEYER ADDRESS SPRINGFIELD, MO.			25. DATE RECD. BY LOCAL REG. 9-2-59		26. REGISTRAR'S SIGNATURE <i>Effie E. Melton</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. J. McCann

Licensed Embalmer No. 272

P. O. Address Springfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.