

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005003

FILED VS. FEB 29 1960 10

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 51

| | | | | | | | | | |
|---|--|--|---|---|-------------------------------------|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Andrain</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u> Length of stay in 1b <u>1 week 4 days</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Andrain Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrain</u> c. CITY OR TOWN <u>Mexico</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>414 E. Breakenridge</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE EDWARD SALLEE</u> | | | | 4. DATE OF DEATH Month Day Year <u>Feb 20-1960</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) <u>60</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Brick</u> | | | 11. BIRTHPLACE (City and state or country) <u>Boone Co Mo U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY | |
| 13a. FATHER'S NAME <u>Mrs Sallee</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Mary Lyons</u> | | | 14. NAME OF HUSBAND OR WIFE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. <u>491-05-6958</u> | | | 17. INFORMANT Address <u>Earl Seath, Mexico, Mo.</u> | | | |
| 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>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 da</u> <u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u> | | | | | | 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 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 <u>1958</u> to <u>Feb 29, 60</u> and last saw him alive on <u>Feb 29, 1960</u> Death occurred at <u>6:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>W. Kallmeyer M.D.</u> | | | | | | 22b. ADDRESS <u>Mexico, Mo</u> | | 22c. DATE SIGNED <u>Feb 22, 60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | | |
| <u>Home</u> | | <u>Feb. 23-1960</u> | | <u>Elmwood</u> | | <u>Mexico, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Mrs Stuart Parker, Columbia, Mo</u> | | | | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | |
| <u>Feb 22-1960</u> | | | | | <u>Feb 22-1960</u> | | <u>Blanche Neely</u> | | |

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

George D. Hammon

Licensed Embalmer No. 4425

P. O. Address Columbus, Ga.

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.