

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

60-013156

FILED VS MAR 17 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2696** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4200 Westminster Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Loretta Middle Sallee Last			4. DATE OF DEATH Month March Day 4 Year 1960
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1900
9. AGE (last birthday) 59		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Tolu, Kentucky
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE William Sallee		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. Unknown
17. INFORMANT Josephine Meissner, 2347 Virginia		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) Hemorrhage, subarachnoid		INTERVAL BETWEEN ONSET AND DEATH 7-10 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Rupture of cerebral aneurysms (rt middle cerebral artery)		7-10 days
	DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral arteriosclerosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 9:50 PM Month, Day, Year 26 February 60	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 St Louis, Mo. COUNTY STATE
21. I attended the deceased from 9:50 PM to 4 March 60 and last saw ^{her} _{him} 4 March 60 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE James F. Wilkel M.D. (Degree title)		22b. ADDRESS St Louis, Mo.	22c. DATE SIGNED 7 Mar 60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-5-60	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) Sikeston, Mo.

24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 8 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

NOV 30 1960

INFORMED

RECEIVED

RECEIVED

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF EMBALMING

BY WHOM

NAME OF EMBALMER

NO. OF LICENSE

CITY

STATE OF

COUNTY OF

0

MAR 23 1960

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 _____

Licensed Embalmer No. 4375

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.

AMERICAN BURIAL & CREMATION CO., INC.