

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008431

Dr. Scanlon

AMENDED

Registration District No. 128 Primary Registration District No. 2005 Registrar's No. 216A

STATE FILE NUMBER

FILED VS MAR 13 1961

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b <b>2 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DOA BURGE HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>907 N. WARREN</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>DONALD WAYNE SALLEE</b>			4. DATE OF DEATH Month Day Year <b>FEB. 26 1961</b>			
--	--	--	---	--	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/29/58</b>	9. AGE (last birthday) <b>2</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	------------------------------------	------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	-----------------------------------	---	---

13a. FATHER'S NAME <b>BOYD SALLEE</b>	13b. MOTHER'S MAIDEN NAME <b>SHIRLEY MEDLEY</b>	14. NAME OF HUSBAND OR WIFE <b>X</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT <b>BOYD SALLEE</b>	Address <b>SPRINGFIELD, MO.</b>
---	--------------------------------------	-------------------------------------	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Likely fulminating Pneumonic infection</i> DUE TO (b) <i>Not known</i> DUE TO (c) <b>UNATTENDED BY A PHYSICIAN</b>		INTERVAL BETWEEN ONSET AND DEATH <i>few hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>upper respiratory infection</i>		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 <b>SPRINGFIELD, MO.</b>	COUNTY <b>GREENE</b>	STATE
---	--	--	---	-------------------------	-------

21. I attended the deceased from 9:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

Death occurred at 9:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <i>James R. Ames, M.D.</i>	(Degree or title) <b>M.D.</b>	22b. ADDRESS <b>Greene Co Health Officer Springfield, Mo.</b>	22c. DATE SIGNED <b>3/6/61</b>
---	----------------------------------	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>3/1/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HAZELWOOD</b>	23d. LOCATION (City, town, or county) <b>SPRINGFIELD, MO.</b>
--	----------------------------	--	--

24. FUNERAL DIRECTOR <b>H.H. LOHMEYER FUNERAL HOME</b>	ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>3-6-61</b>	26. REGISTRAR'S SIGNATURE <i>Effie G. Shelton</i>
---	------------------------------------	---	--

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

**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 *[Handwritten Signature]*

Licensed Embalmer No. 2727

P. O. Address *[Handwritten 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.