MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Jasper

Township or Village or City Webb City (No. Jasper Co. Tub. Hospital St.; Ward)

Registration District No. 417 File No. 19968

Primary Registration District No. 307 Registered No. 115

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alexander B. Saltman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX White

4 COLOR OR RACE Male

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 22 (Month) (Day) 1857 (Year)

7 AGE 60 yrs. 10 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Ohio

PARENTS

10 NAME OF FATHER John K. Saltman

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Other

12 MAIDEN NAME OF MOTHER Jane Barkley

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Davis

(Address) Carthage Mo

15 Filed 6/16 1919 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 16 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 6-13 1919, to 6-15 1919, that I last saw him alive on 6-15 1919, and that death occurred, on the date stated above, at 39 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

23A

(Duration) 28 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. Kirtley M. D.

6-16 1919 (Address) Webb City Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence Jasper Mo.

19 PLACE OF BURIAL OR REMOVAL Jasper Mo

DATE OF BURIAL 6-17 1919

20 UNDERTAKER Fortune Bud Co

ADDRESS Jasper Mo

MISSOURI STATE BOARD OF HE/
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City.....(NO....., ...St.;.....Ward)

[If death occ
hospital or i
give its NAM
of street and

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

.....(Month) (Day), 1.....(Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

.....(Month) (Day), 19

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to....., 1

that I last saw h.....alive on....., 1

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Ca
(1) Means of Injury; and (2) whether Accidental, Suicidal or Ho

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tra
or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos..

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

.....,

20 UNDERTAKER

ADDRESS

GEO. H. JONES, M. D.