

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

Do not use this space.

12509

1. PLACE OF DEATH  
 County Callaway Registration District No. 109  
 Township Caldwell Primary Registration District No. 5759  
 City..... (No.....) St. .... Ward)

File No.....  
 Registered No. 417

2. FULL NAME Orla Snow Salmons  
 (a) Residence, No..... St. .... Ward.....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12 - 1927

7. AGE YEARS MONTHS DAYS IF LESS than a day; hrs. or min.  
7 21

8. OCCUPATION OF DECEASED None  
 (a) Trade, profession, or particular kind of work.....  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer Mo.

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Orla Snow Salmons

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Edna Curnutt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) Mo.

14. INFORMANT O.S. Salmons  
 (Address) R.F.D. Fulton Mo.

15. FILED 4/10 1928 Caldwell REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/3 28 19

17. I HEREBY CERTIFY. That I attended deceased from 3/31/1928 to 4/3/1928 that I last saw him alive on 4/3/1928 and that death occurred, on the date stated above, at 6P.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bronchial Pneumonia  
11H  
107A (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Influenza  
 (duration) yrs. mos. da. 8

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF X

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) C.H. Christian, M.D.  
Fulton Mo., 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Carmel Church DATE OF BURIAL 4/4 28

20. UNDERTAKER Herndon Taylor ADDRESS Fulton Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

4 1928

