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.

I X16605

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

36721
Do not use this space.

1. PLACE OF DEATH

(a) County Montgomery 2 Registration District No. 593

(b) Township Danville Primary Registration District No. 4-3-51 Registered No. 77

(c) or City near New Florence Mo (d) Street No. 5 984 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 50 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

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2. PRINT FULL NAME Cora Bell Salaman

(a) Residence, No. near New Florence Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
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) 11/1/1868

7. AGE: YEARS 70 MONTHS 10 DAYS 26 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Pratical Nurse
9. Industry or business in which work was done, as saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Guggsville Ill

FATHER
13. NAME Robt Salaman
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va

MOTHER
15. MAIDEN NAME Rebecca Jamison
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va

17. INFORMANT (ADDRESS) Lela Campbell New Florence Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE New Florence Mo DATE 9/29/39 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C W Hopkins Montgomery City Mo

20. FILED 11/10/39 19 James C. Helm M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/28/39 19

22. I HEREBY CERTIFY, That I attended deceased from March 1, 1939 to Sept. 28, 1939

I last saw her alive on Sept. 26, 1939 Death is said to have occurred on the date stated above, at 1 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
1. Valvular Heart Disease, Mitral Insuffiency	
2. Arterial hpertension	
3. Arterio-sclerosis	

Other contributory causes of importance: 92 W

Name of operation ..... Date of .....

What test confirmed diagnosis? Phys. Exam Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Brull Menefee, M. D.

(Address) Montgomery City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 on the 28th day of Sept 1939, Registered Apprentice No. ....., working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 1487

P. O. Address Marthy Ave City Mo

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 this body is not embalmed, above space should be left blank.