

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.

1. PLACE OF DEATH:
 (a) County 1
 (b) City or town St Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Kevin Desloge
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Roger (stillborn) Curtis Salaman 455
3. (b) If veteran, _____ **3. (c) Social Security** _____
 name war _____ No. _____

4. Sex Male **5. Color or race** W **6. (a) Single, widowed, married,** _____
 divorced _____
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
 alive _____ years

7. Birth date of deceased November 7, 1939
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____
 hr. _____ min. _____

9. Birthplace St Louis, Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Salaman
13. Birthplace Crystal City, Mo
 (City, town, or county) (State or foreign country)
14. Maiden name Eleanor Oakley
15. Birthplace St. Louis, Mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph Salaman
(b) Address 1503 a Park ave St. Louis mo.

17. (a) Burial **(b) Date thereof 12-8-39
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Matthews**

18. (a) Signature of funeral director J. W. McLaughlin
(b) Address 2301 Lafayette

19. (a) DEC 8 1939 **(b)** _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St Louis **22**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1503 a Park Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month November day 7 247
 year _____ hour _____ minute _____ P.M.
21. I hereby certify that I attended the deceased from _____
 _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Still born
Cause?

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature G. P. Morgan M.D. (M. D. or other) _____
Address 1255 Shaw **Date signed** 12/8/39

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

L. K. Cooper

Licensed Embalmer No. *3633*

P. O. Address *2317 P. O. Box*

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.