

WRITE PLAIN!—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REV. 5-17-39 I 193511

14026. 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 975
Registrar's No. 975

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether _____)
In this community unknown
years, months or days

FILED FEB 17 1940

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____ X
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 19
(d) Street No. 4384 McPherson
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ X _____ years.

3. (a) PRINT FULL NAME James Salmon
(b) If veteran, name war unknown
(c) Social Security No. unknown
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced unknown
6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years abt. 78 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace New York
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business _____

MOTHER FATHER { 12. Name unknown

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address City Hospital, #1

17. (a) _____ (b) Date received _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JAN 31 1940 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 13,
year 1940 hour 8:25 minute _____ A. M.

21. I hereby certify that I attended the deceased from January 10, 1940 to January 13, 1940
that I last saw him live on January 13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Legislative Heart Disease
Duration _____

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature C. Porecz (M. D. or other) _____
Address 1515 Lafayette Date signed 1/13/40

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 _____

Licensed Embalmer No. _____

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