

State File No. \_\_\_\_\_

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 43

1. PLACE OF DEATH: Phelps

(a) County: \_\_\_\_\_

(b) City or town: Rolla  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: at home in S.W. Rolla  
(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: Forest Salts 432

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex: Male

5. Color or race: White

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: Dec 13 1909  
(Month) (Day) (Year)

8. AGE: Years 30 Months 3 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Rolla Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation: Day Laborer

11. Industry or business: Philip Salts

12. Name: Rolla

13. Birthplace: Rolla Mo  
(City, town, or county) (State or foreign country)

14. Maiden name: Little Hargis

15. Birthplace: Roseman Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant: Philip Salts  
Rolla Mo

(b) Address: Pilot Knob

17. (a) \_\_\_\_\_ (b) Date thereof: April 4 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Pilot Knob

18. (a) Signature of funeral director: Null & Son  
Rolla

(b) Address: \_\_\_\_\_

19. (a) April 4, 1940 (b) Joe F. Rogers  
(Date received by Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: Phelps

(c) City or town: Rolla  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR 2 day \_\_\_\_\_  
year 1940 hour 11 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb 1st 40  
\_\_\_\_\_ 19\_\_\_\_ to APR 2nd 1940;  
that I last saw him alive on March 20 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary tuberculosis 1 yr

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?  
610 \_\_\_\_\_  
(Specify name of place)

While at work? \_\_\_\_\_

23. Signature: James (M. D. or other) \_\_\_\_\_  
Address: James Date signed: 4/5/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

31  
2  
1

**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.

**District Health Officer No. 5,**

Signed.....

District File Number 440 399

Licensed Embalmer No.....

Date Filed 4/1/40

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12027

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Phelps  
(b) City or town Patton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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 Forest Salts

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 30 Months 3 Days 21 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) May 14, 1940 (b) Joe. F. Ayers  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 2  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature Egail A. Strickland (Name or other)

Address St James \_\_\_\_\_ signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940  
S-12027