

FILED SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29360

Registration District No. 678

Primary Registration District No. 5904

Registrar's No.

I. PLACE OF DEATH

(a) County Phelps
(b) City or town St James Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St James Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether years, months or days) 11 1/2

8. (a) PRINT FULL NAME Christina B. Saltz

8. (b) If veteran, name war No. 8. (c) Social Security No.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced, or widowed Married

6. (b) Name of husband or wife Louis Saltz 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 2 1913 (Month) (Day) (Year)

8. AGE: Years 27 Months 7 Days 4 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name E. S. Whisher

18. Birthplace Ralls Mo (City, town, or county) (State or foreign country)

14. Maiden name Julia Cox

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

16. (a) Informant Mrs. Minnie Tucker

(b) Address San Luis Obispo Cal

17. (a) (b) Date thereof 9-24-40 (Month) (Day) (Year)

(c) Place: burial or cremation Ralls Ralls

18. (a) Signature of funeral director [Signature] (b) Address Ralls Mo

19. (a) 9-9-40 (Date received local registrar) (b) Elsie P. Dour (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town Ralls
(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 Sept day 6 year 1940 hour 3:00 minute 7:00 P.M.

21. I hereby certify that I attended the deceased from 9-4-40, 1940 to 9-6-40, 1940 that I last saw her alive on 9-5-40 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Peritonitis

Due to

Due to

Other conditions Ch. appendicitis (Include pregnancy within 3 months of death)

Major findings: Ch. appendicitis
Of operations: Ch. Salpingitis
Of autopsy

Duration

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. E. Feind M.D. (D. or other) Address Ralls Mo Date signed 9-6-40

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

17-39 X21492

121

RECEIVED

District Health Officer No. 5,

District File Number 240929

Date Filed _____

Mrs. Hook

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 *S. L. Milled*

Licensed Embalmer No. *3294*

P. O. Address *Rochester*

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. 29360

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 678

Primary Registration District No. 5904

Registrar's No. _____

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

1. PLACE OF DEATH
 (a) County Bellevue
 (b) City or town James T. P.
(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) PRESENT FULL NAME Christina G. Salts
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex f 5. Color or race w
 6. (a) Single, widowed, married, divorced m
 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 Months Days If less than one hr. min.
27 7 4 _____

9. Birthplace (City, town, or county) (State or foreign country)
 10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER
 { 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) _____ (b) _____
(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

20. DATE OF DEATH Month Sept day 6
 year 1940 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 Suberculous Peritonitis Duration 2 weeks

Other conditions Chr. appendicitis
(Include pregnancy within 3 months of death)
 Major findings: Chr. Salpingitis (lateral)
 Of operations _____
 Of autopsy _____
 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?
(Specify type of place)
 While at work? (c) Means of injury _____
 23. Signature E. E. Ferris (M. D. MD)
Rolla Mo. Date signed 11-23-40
 Address _____

SUPPLEMENTAL

