

STANDARD CERTIFICATE OF DEATH

Registration District No. 887 Primary Registration District No. 6182 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Washington  
(b) City or town Old Mines, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Admission 7  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wash 110  
(c) City or town Old Mines, Mo 1  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26  
year 1941 hour 8:15 minute P.M.

21. I hereby certify that I attended the deceased from March 25 1941 to March 26 1941  
that I last saw her alive on March 26 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: Thrombosis coronary arteries

Due to following  
Due to Influenza

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 940  
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 J. F. Presswell (M. D. or other) MD  
Address Old Mines, Mo Date signed 3/27/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3. (a) PRINT FULL NAME Pauline Salusander

8. (b) If veteran, name war 1 8. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 Aug 11 1919  
(Month) (Day) (Year)

8. AGE: Years 21 Months 7 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace San Francisco, Cal  
(City, town, or county) (State or foreign country)

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

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

MOTHER FATHER { 12. Name A. F. Salusander  
13. Birthplace Blundale, Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Lie Lassalle  
16. Birthplace St. Joseph, Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant A. F. Salusander

(b) Address Old Mines, Mo

17. (a) Burial (b) Date thereof Mar 28 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Sparks

(b) Address Pataskala, Mo

19. (a) Mar 27 41 (b) J. F. Presswell  
(Date received local registrar) (Registrar's signature)

**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.**