

13-40  
17-39  
X23159

FILED AUG 23 1941

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

Registration District No. 837

Primary Registration District No. 6099

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Paris - Boston Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard

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

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

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

3. (a) PRINT FULL NAME MITCHELL SALTSGIVER

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 Widowed

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 70 Months 7 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace unknown (State or foreign country)

10. Usual occupation unknown

11. Industry or business unknown

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 Dr. Blevins

(b) Address Bronfield, Mo.

17. (a) Burial (b) Date thereof 7/14/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation at home

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

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

19. (a) July 5 - 1941 (b) Joanice Lunch  
(Date received local registrar) (Registrar's signature)

870 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1941 hour 1.5 minute 30 A. M.

21. I hereby certify that I attended the deceased from June 23, 1941, to July 14, 1941, that I last saw him alive on July 12, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis

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

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

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations \_\_\_\_\_ Of autopsy None

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 John W. Blevins (M. D. or other) \_\_\_\_\_ Address Bronfield, Mo. Date signed 7/15/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3  
0  
5

RECEIVED

District Health Office No.

District File Number 841-111

Date Filed 8-15-41

---

---

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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 263817

Registration District No. 837

Primary Registration District No. 6099

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Paris  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: County Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay in hospital or institution 1 day  
(Specify whether  
In this community 1 day  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stoddard  
(c) City or town Bell City  
(If outside city or town limits, write "RURAL")  
(d) Street No. ?  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mitchell Saltzgeber

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, wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

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

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

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

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) Oct 1 '44 (b) Looney Tunch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ 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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

[The page contains extremely faint and illegible text, likely a scan of a document with very low contrast or significant noise. No specific words or structures are discernible.]