

FILED OCT 13 1943

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **8608**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **0** (Specify whether)
In this community **1 Day**
years, months or days

3. (a) PRINT FULL NAME **Charles H Salmon**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Eugenia** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Jan 14th. 1860**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 **8** **9** _____ hr. _____ min.

9. Birthplace **New Orleans, La.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Insurance Adjuster**

11. Industry or business **Unemployed**

12. Name **George Salmon**

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

14. Maiden name **Saddie Gunn**

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

16. (a) Informant **Henrietta Salmon**

(b) Address **610 Eastgate Ave**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9/30/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemt.**

18. (a) Signature of funeral director **Harrison & Sheahan Und Co**

(b) Address **4415 Washington Blvd.**

19. (a) **SEP 22 1943** (Date received from registrar) **J. J. [Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **610 Eastgate Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **28th.**
year **1943** hour **8:30 AM** 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 _____

Carcinoma of Liver
Due to **metastasis**

Due to _____

Other conditions (include pregnancy within 3 months of death) **H. J. [Signature]**

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) Means of injury _____

23. Signature **J. J. [Signature]** (M.D. or other) _____

Address **1300 Clark** Date signed **9/29/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1667

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.....

John G. Gonski

Licensed Embalmer No.....

3398

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.