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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40359**

FILED DEC 29 1945

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Grim-Smith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community 40 years
years, months or days)

3. (a) PRINT FULL NAME Harold Salzer
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 /
6. (b) Name of husband or wife C. Salzer
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased: Feb 5 1883
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 4
If less than one day hr. min.

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

10. Usual occupation Tram keeper

11. Industry or business

MOTHER FATHER

12. Name Harold Salzer
13. Birthplace Knox Co, Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Gertrude Herington
15. Birthplace Knox Co, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant C. A. Salzer
(b) Address Novelty Mo

17. (a) Burial (b) Date there Nov 11-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or Novelty Mo

18. (a) Signature of funeral director J. S. Smith
(b) Address La Plata Mo

19. (a) 11-13-45 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
(c) City or town Novelty - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29 year 1945 hour 12 minute 10 M.
21. I hereby certify that I attended the deceased from Oct 29 1945 to Nov 9 1945
that I last saw er alive on November 9 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Lymphatic Leukemia
Duration 1 year

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None
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?

(Specify type of place) While at work? (e) Means of injury
23. Signature W. K. Ragsdale (M. D. or other)
Address Novelty Mo Date signed 11-9-45

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

