DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 864

FILED JAN 21 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 58

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:
Home of the Friendless 4431 S. Broadway
(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)

In this community

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. 4431 S. Broadway
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MRS MAMIE SALISBURY

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife William H. Salisbury

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October (Month) 3 (Day) 1863 (Year)

8. AGE: Years 82 Months 2 Days 29 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name John J. Flippin

13. Birthplace Burkville (City, town, or county) Virginia (State or foreign country)

14. Maiden name Mary Flippin

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

16. (a) Informant Mrs. M. Jones

(b) Address 4431 S. Broadway

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 46 (Month) (Day) (Year)

(c) Place: burial or cremation Fee Fee Cemeteery

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 7814 S. Broadway

19. (a) JAN 1 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2nd year 1946 hour 10 minute A M.

21. I hereby certify that I attended the deceased from June 1929 to Jan 2 1946 that I last saw her alive on Jan 1 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	1 week
Myocarditis	1 week
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Parkinson Disease (Paralysis Agitans)	15 yrs

Major findings:
Of operations no
Of autopsy no

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) no

(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 Chas E. Hyndman (M. D. or other) MD

Address 3720 Washington Date signed 1/2/46

(Licensed Embalmer's Statement on Reverse Side)

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 Harry J Schumacher

Licensed Embalmer No. 2679

P. O. Address 7814 S. Broadway

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Hutchinson

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State File No. Zeb

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 58

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:

(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)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mamie Salisburg

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 2

5. Color or race W

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife William

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 3 (Day) 1864 (Year)

8. AGE: Years 82 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature) JAN 04 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h 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)

(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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

3054

864