. No. 2
—8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 9 1946

Dr. Stahl

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12861

Registration District No. 128 — Primary Registration District No. 2000 — Registrar's No. 349

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 700 E. Lombard (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: 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 37
(c) City or town: Springfield 2 (If outside city or town limits, write "RURAL")
(d) Street No.: 700 E. Lombard 6 (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) 0
If yes, name country: ____

3. (a) PRINT FULL NAME: William Alexander Salts
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Nancy Irene Salts
6. (c) Age of husband or wife if alive: Dec. years
7. Birth date of deceased: May (Month) 29 (Day) 1875 (Year)
8. AGE: Years 70 Months 10 Days 23 If less than one day ____ hr. ____ min.
9. Birthplace: Rock Falls (City, town, or county) Tennessee (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: Druggist
MOTHER FATHER
12. Name: Arch Salts
13. Birthplace: Rock Falls (City, town, or county) Tennessee (State or foreign country)
14. Maiden name: Sarah Brumley
15. Birthplace: Rock Falls (City, town, or county) Tennessee (State or foreign country)
16. (a) Informant: W. Howard Salts
(b) Address: Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/24/46 (Month) (Day) (Year)
(c) Place: burial or cremation: Clear Creek
18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.
19. (a) 4-24-46 (Date received local registrar) (b) B. W. Hardley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22 year 1946 hour 11 minute 45a. M.
21. I hereby certify that I attended the deceased from Mar. 1, 1944 to Apr. 22, 1946 and that I last saw him alive on Apr. 19, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertrophy of Prostate	2 yr.
Due to: and Chronic Cystitis	
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 0
23. Signature: Fred A. Stahl M.D. (M. D. or other)
Address: 307 Woodruff Bldg. Springfield, Mo. Date signed 4-22-46

FRED A. STAHL, M.D.
307 WOODRUFF BLDG.
SPRINGFIELD, MISSOURI

111 (Licensed Embalmer's Statement on Reverse Side)

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

11766

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. Walter E. Hamilton

Licensed Embalmer No. 3808

P. O. Address Springfield, Mo.

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.

4