

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED DEC 8 1946**  
Registration District No. 374

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 42

Primary Registration District No. 415-47

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

1. PLACE OF DEATH  
(a) County North County  
(b) City or town Grant City Mo  
(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)  
In this community Entire life years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County North  
(c) City or town Grant City Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sareta M Salmon  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 24 year 1946 hour 1:30 minute \_\_\_\_\_ P.M.  
21. I hereby certify that I attended the deceased from June 10 to Nov 24-46 that I last saw her alive on Nov 22 1946 and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife North Salmon 6. (c) Age of husband or wife if alive 81 years  
7. Birth date of deceased Sept 13 1866  
(Month) (Day) (Year)

Immediate cause of death Intestinal neoplasia  
Duration 5 yrs

8. AGE: Years 80 Months 2 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace North County Mo (City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business \_\_\_\_\_

Other conditions hypertension (Include pregnancy within 6 months of death) 3 yrs  
Major findings: 131A  
Of operations no  
Of autopsy no

MOTHER FATHER  
12. Name William H Brecker  
13. Birthplace Penn (City, town, or county) (State or foreign country)  
14. Maiden name Sarah L Hathaway  
15. Birthplace Indiana (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Clayton W Salmon  
(b) Address Grant City Mo  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26-46 (Month) (Day) (Year)  
(c) Place: burial or cremation Grant City Cemetery

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) (e) Means of injury

18. (a) Signature of funeral director John Anderson  
(b) Address Grant City Mo  
19. (a) Nov 25-46 (Date received local registrar) (b) Letta E Dawson (Registrar's signature)

23. Signature J Ross (M. D. or other) \_\_\_\_\_  
Address Grant City Mo Date signed Nov 24 46

DISTRICT HEALTH OFFICE  
Cameron, Mo.

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.....

*John Andrews*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *John Andrews*.....

Licensed Embalmer No. *4211*.....

P. O. Address..... *Grant City 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.