

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 5135 Registrar's No. 260

1. PLACE OF DEATH

a. COUNTY Butler

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fisk Rural Ash Hill

c. LENGTH OF STAY (In this place) Life

d. FULL NAME OF HOSPITAL OR INSTITUTION _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE Missouri b. COUNTY Butler

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fisk Rural Ash Hill Twp.

4. STREET ADDRESS (If rural, give location) Rfd. 1

3. NAME OF DECEASED

a. (First) Lutincy b. (Middle) Ann c. (Last) Saltzman

4. DATE OF DEATH (Month) (Day) (Year) June 23 1949

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH March 4, 1877 9. AGE (In years last birthday) 72 3 19 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY House work 11. BIRTHPLACE (State or foreign country) Fisk, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Charles Hayes 13b. MOTHER'S MAIDEN NAME _____ 14. NAME OF HUSBAND OR WIFE Husband dead

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Earl Saltzman ADDRESS St. Louis, Mo.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 331X

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from July, 1947, to June, 1949, that I last saw the deceased alive on June 21, 1949, and that death occurred at 10:20 am., from the causes and on the date stated above.

23a. SIGNATURE W. B. Skilling, M.D. (Degree or title) 23b. ADDRESS Fisk Mo. 23c. DATE SIGNED June 25/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 6-24-49 24c. NAME OF CEMETERY OR CREMATORY Vale Cemetery 24d. LOCATION (City, town, or county) (State) Fisk, Mo. Rfd. 1

DATE REC'D BY LOCAL REG. July 12, 1949 REGISTRAR'S SIGNATURE Wm. B. Johnson 428 25. FUNERAL DIRECTOR'S SIGNATURE Watkins Funeral Ser. ADDRESS Dexter, Mo.

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

JUL 18 REC'D
BUTLER COUNTY HEALTH CENTER
COPPER SPRING, MISSOURI

749-188

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

B J Brentlinger

Licensed Embalmer No. *4201*

P. O. Address *Oxley, 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.