

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38287

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>278</u>		PRIMARY REG. DIST. NO. <u>3054</u>		Registrar's No. <u>95</u>		
1. PLACE OF DEATH a. COUNTY <u>Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Louisiana</u>		c. LENGTH OF STAY (in this place) <u>15 months</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Louisiana</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1102 Tennessee St.</u>				d. STREET ADDRESS (If rural, give location) <u>1102 Tennessee St.</u>				
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH					
a. (First) <u>CHARLES</u>		b. (Middle) <u>C</u>		c. (Last) <u>SOLOMON</u>		Nov. 16, 1949		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 14, 1869</u>		
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dairyman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Business</u>			11. BIRTHPLACE (State or foreign country) <u>Germany</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			13a. FATHER'S NAME <u>Karl Solomon</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Ora Rodgers Solomon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ora Solomon--Louisiana, Missouri</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>left Hemiplegia from</u> DUE TO (c) <u>Cerebral Hemorrhage</u>				4 1/2		
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>and Thrombosis</u>				1 year.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR				
22. I hereby certify that I attended the deceased from <u>Sept. 7, 1948</u> , to <u>Nov. 16, 1949</u> , that I last saw the deceased alive on <u>11-15, 1949</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Robert L. Andrae, M.D.</u> ROBERT L. ANDRAE, M.D.				23b. ADDRESS <u>216 Georgia St. Louisiana, Mo.</u>		23c. DATE SIGNED <u>11-17-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Nov. 19, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory St. Louis, Mo.</u>		24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. <u>Nov 18, 1949</u>		REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sterne Funeral Home--Louisiana, Mo.</u>				

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

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RECEIVED NOV 28 1913  
District Health Officer No. \_\_\_\_\_  
District File Number 11-42-19  
Date Filed NOV 28 1913

**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 Virginia M. Sterne  
Licensed Embalmer No. 4645

P. O. Address Louisiana, 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.