

DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39246

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1003

State File No. 10512  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 10512		Registrar's No. _____					
1. PLACE OF DEATH <i>St. Johns Hospital</i> a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>St Charles</i>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St Louis Mo</i>		c. LENGTH OF STAY (In this place) <i>3 days</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>O'Fallon</i>		Rural <i>92</i>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Johns Hospital</i>				d. STREET ADDRESS (If rural, give location) <i>N.R.</i>									
3. NAME OF DECEASED a. (First) <i>Deloris</i>			b. (Middle) <i>Rita</i>			c. (Last) <i>Saltzen</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>Dec 5 1949</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Aug 8 1930</i>		9. AGE (In years last birthday) <i>19</i>		If UNDER 1 YEAR Months <i>3</i> Days <i>27</i>		If UNDER 4 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Duties</i>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) <i>Josephville Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13a. FATHER'S NAME <i>Henry Sommer</i>				13b. MOTHER'S MAIDEN NAME <i>Paulene Rothermich</i>				14. NAME OF HUSBAND OR WIFE <i>Adfred R Saltzen</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <i>Adfred R. Saltzen</i>						ADDRESS <i>O'Fallon Mo</i>	
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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Eclampsia</i> 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 <i>48 hrs</i>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <i>14th St</i>									
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 <i>685X</i>									
22. I hereby certify that I attended the deceased from <i>July 1949</i> , to <i>Dec. 5</i> , 1949, that I last saw the deceased alive on <i>12/5</i> , 1949, and that death occurred at <i>4:05</i> p.m., from the causes and on the date stated above.													
23a. SIGNATURE <i>H.C. Mc Murray M.D.</i>						23b. ADDRESS <i>Westville Mo.</i>		23c. DATE SIGNED <i>12/5/49</i>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24b. DATE <i>12-7-49</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Immaculate Conception</i>		24d. LOCATION (City, town, or county) (State) <i>Dardenne Mo</i>							
DATE REC'D BY LOCAL REG. <i>DEC 6 1949</i>		REGISTRAR'S SIGNATURE <i>J.B. Casater</i>				25. FUNERAL DIRECTOR'S SIGNATURE <i>T.B. Starnum</i>				ADDRESS <i>Westville Mo</i>			

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

1961 8 1 NQA

**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.

Signed.....  
Student Embalmer

Signed Robert H Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, 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.