

FILED FEB 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7067  
Registrar's No. 455

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3070

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Webster Groves</u>		c. LENGTH OF STAY (in this place) <u>20 yrs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>324 S Maple</u>		d. STREET ADDRESS (If rural, give location) <u>324 S Maple</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Charlotte</u>	b. (Middle) <u>Hamann</u>	c. (Last) <u>Salveter</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 20 1950</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct. 24 1908</u>	9. AGE (to years last birthday) <u>41</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Sofia Meyer</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Earl Salveter</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Robert Earl Salveter</u>	ADDRESS _____
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>8-29-47</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Occlusion in Posterior Coronary Artery</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Occlusion in Anterior Coronary Artery</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____ DUE TO (c) <u>Coronary Artery disease</u>		
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>420.1</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from 8-29, 1947, to 2-18-, 1950, that I last saw the deceased alive on 2-18-, 1950, and that death occurred at 12:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>H.A. [Signature]</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>19 E. Lockwood, Webster Groves, Missouri</u>	23c. DATE SIGNED <u>2-20-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb 22 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kirkwood Mo.</u>
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DATE REC'D BY LOCAL REG. <u>2-21-50</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Webster Groves Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

**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 \_\_\_\_\_

*Leslie Welch*

Licensed Embalmer No. \_\_\_\_\_

*4395*

P. O. Address \_\_\_\_\_

*Walter Groves M*

**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.