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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39967**

Registration District No. **FILED DEC 11 1940** 843
Mandatory Registration District No. **6106**
Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Stone Co. Wash Mo**
(b) City or town **Halena mo Star Prairie**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Stone**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
In this community **about 15 yrs**
(Specify whether years, months or days)

(d) Street No. **0**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **J. T. Saltkill**
3. (b) If veteran, name war _____
3. (c) Social Security No. **500-05-9059**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **9**
year **1940** hour **3:15** minute **A.** M.

4. Sex **m**
5. Color or race **wch**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mamie**
6. (c) Age of husband or wife if alive **35** years
7. Birth date of deceased **Jan. 20 1890**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death **Malignant hypertension. ?**
Duration _____

8. AGE: Years Months Days If less than one day
50 **8** **28** hr. _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) **10/2**

9. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
10. Usual occupation **farmer and black smith**
11. Industry or business _____
12. Name **Samuel Saltkill**
13. Birthplace **Indiana in country**
(City, town, or county) (State or foreign country)
14. Maiden name **Rhoda G. Casler**
15. Birthplace **Middle Tenn**
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mamie Saltkill**
(b) Address **Halena mo Star Prairie**
17. (a) **Burial** (b) Date thereof **Nov 11-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Halena cemetery**
18. (a) Signature of funeral director **Ereth J. Cheatham**
(b) Address **Halena mo**
19. (a) **Nov 11 1940** (b) **Nellie Ironley**
(Date received local registrar) (Registrar's signature)

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? **7:15**
While at work? (Specify type of place) (e) Means of injury _____
23. Signature **A. P. Peterson** (M. D. or other) _____
Address **Halena mo** Date signed **11-9-40**

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

Body was not Embalmed.

RECEIVED

District Health Officer No. 6,

District File Number: 12402969

Date Filed: DEC 9 1940

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39967

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 843

Primary Registration District No. 6106

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Wash. T. P.
(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 _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

James L. Balthill

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 50 Months 9 Days 19 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Nov. 11, 1940 (b) Nellie Ironley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____
Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

23. Signature G. P. Cappetti (M. D. or other) _____
Address Crane Date signed _____

SUPPLEMENTARY

1940

S-39967