

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

FILED MAR 15 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 1000

Registrar's No. 224

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

11  
1  
7

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution State Hosp # 23  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days  
(Specify whether years, months or days) same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Macon  
(If outside city or town limits, write "RURAL")

(d) Street No. Co. farm  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Louis Saling

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 3  
year 1944 hour 11 minute 55 A.M.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced 9

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) ? (Day) ? (Year) ?

21. I hereby certify that I attended the deceased from Feb 12 1944, to Mar 3 1944  
that I last saw him alive on Mar 3 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months ? Days ?  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Broncho pneumonia Duration short

9. Birthplace ? (City, town, or county) \_\_\_\_\_ (State or foreign country) 9

Due to Hypostasis

Due to \_\_\_\_\_

10. Usual occupation Work on County farm

Other conditions (Include pregnancy within 3 months of death) 107

11. Industry or business ✓

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

12. Name ?

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) 9

14. Maiden name ?

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) ?

16. (a) Informant Sheriff, Macon Co

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 3-6-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macy Co. Mo Mt. Lebanon

18. (a) Signature of funeral director Stephen Gooding  
Macon, Mo.

(b) Address \_\_\_\_\_

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 0

19. (a) 3-6-44 (b) One Hegag  
(Date received local registrar) (Registrar's signature)

23. Signature E.H. Magee (M. D. or other) MD

Address State Hosp #2 Date signed 3/3/44

**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. 3057

P. O. Address Macou, 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.