

S. No. 2
 FORM-2-43
 Rev. 5-17-39
 X35897

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED JUL 1 1946
 Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
 Primary Registration District No. 2000

20006
 State File No. _____
 Registrar's No. 498

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Josephine's Rest Home 4
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Dns.
(Specify whether years, months or days)
 In this community 69 Years

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County Greene 39
 (c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 1404 N. Roberson Ave. 6
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH SALSMAN, SR.
 3. (b) If veteran, name war None
 3. (c) Social Security No. 497-24-6326

4. Sex male 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Grace Salsman
 6. (c) Age of husband or wife if alive 54 years
 7. Birth date of deceased June 12, 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 28
 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business barber

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name UNKNOWN
 15. Birthplace Unknown Unknown 11
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Grace Salsman
 (b) Address 1404 N. Roberson Ave., Spfld., Mo.

17. (a) burial (b) Date thereof June 12, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazelwood Cemetery

18. (a) Signature of funeral director Frederic Thleme

(b) Address Springfield, Mo.

19. (a) 6-12-46 (b) S. W. S. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10th
 year 1946 hour 6:00 P.M. minute _____ M. _____

21. I hereby certify that I attended the deceased from 5-15-46 to 6-10-46
 that I last saw him alive on 6-9-46
 and that death occurred on the date and hour stated above.

Immediate cause of death Neuroplizia
 Duration 4 wks.

Due to Arteriosclerosis

Due to Hypertension

Other Conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 C. E. Fuller (M. D. certified)
 Address Springfield, Mo. Date signed 6/11/46

WRITE PLAINLY—USE 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.....

....., Registered Apprentice No. 3651

working under my personal supervision.

Signed.....

Ralph Thorne

..... Licensed Embalmer No. 3651

..... P. O. Address Springfield, 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.