

FILED APR 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15221
Registrar's No. 81

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Saline</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Marshall</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Slater</i> 0791	
c. LENGTH OF STAY (If this place) <i>30 hours</i>		d. STREET ADDRESS (If rural, give location) <i>324 Locust</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Stitzelblon Hospital</i>			
3. NAME OF DECEASED (Type or Print) a. (First) <i>FLORENCE</i> b. (Middle) <i>ELIZABETH</i> c. (Last) <i>SALZER</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>April 13 1951</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>Sept. 29-1895</i>
9. AGE (In years last birthday) <i>55</i>		10. MONTHS <i>6</i>	11. DAYS <i>24</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Pratt Kansas</i>
12. CITIZENSHIP OF DECEASED <i>USA</i>			
13a. FATHER'S NAME <i>John E Jones</i>		13b. MOTHER'S MAIDEN NAME <i>Lucy Kate Hawkins</i>	
14. NAME OF HUSBAND OR WIFE <i>Norman Salzer</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no no</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <i>James E Jones, Slater Mo</i>		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Stroke Hemiplegia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs</i>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <i>Cerebrovascular Lesion</i>	
DUE TO (c) _____		2. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION <i>None</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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>Slater Mo</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>None</i>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>None</i>			
22. I hereby certify that I attended the deceased from <i>April 10</i> , 1951, to <i>April 12</i> , 1951, that I last saw the deceased alive on <i>April 12</i> , 1951, and that death occurred at <i>6:45 a.m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>J. E. Salzer M.D.</i> (Degree or title)		23b. ADDRESS <i>Slater Mo</i>	
23c. DATE SIGNED <i>4-14-51</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>April 15 1951</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Slater City Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Slater Mo</i>	
DATE REC'D BY LOCAL REG. <i>April-14-1951</i>		REGISTRAR'S SIGNATURE <i>385</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>J. Leslie Perryman</i>		ADDRESS <i>Marshall Mo</i>	

(Licensed Embalmer's Statement on Reverse Side)

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

972
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RECEIVED 4-16-51

DISTRICT HEALTH OFFICE No. 3

District File Number -----

Date Filed 4-16-51 -----

MAY 1 1951

MAY 16 1951

AUG 11 1951

MAY 16 1951

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 -----

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *J. Lebi Sussney* -----

Licensed Embalmer No. *3235* -----

P. O. Address *Marshall St* -----

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.