

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

16733

4673

1. PLACE OF DEATH

County.....

Registration District No.....

791

1003

Township.....

Primary Registration District No.....

City.....

(No. of City Hospitals)

File No.....

Registered No.....

St.....

Ward.....

2. FULL NAME

(a) Residence. No. 4144 Westminster 19. Ward.....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da.

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

male | white | married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 4 - 1866

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

61 | 2 | 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Auto Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Michigan

10. NAME OF FATHER

Wm. Slidden

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

New York

12. MAIDEN NAME OF MOTHER

Anna Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

New York

14.

INFORMANT

(Address)

Wm. Slidden
City Hosp

15.

FILED

MAY 18 1927

Mar 6 Starkey

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

May 9 1927

17.

I HEREBY CERTIFY That I attended deceased from March 4 1927 to May 9 1927 that I last saw him alive on May 9 1927 and that death occurred, on the date stated above, at 458 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

93C

CONTRIBUTORY (SECONDARY)

POB

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

8. DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Shoswimmer, M. D.

10, 1927

(Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Valhalla

5/19 1927

20. UNDERTAKER

ADDRESS

Abell 5240 Alma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Slidden