

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

14763
 Do not use this space.

RECORDED MAY 24 1939

1. PLACE OF DEATH
 (a) County Douglas Registration District No. 276
 (b) Township Wheat Primary Registration District No. 5279
 (c) City Vergant (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
 450
 2. PRINT FULL NAME George Washington Sloan
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Clara Sloan
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-4-1868
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 0 27
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 FATHER 13. NAME John Sloan
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 MOTHER 15. MAIDEN NAME May Rogers
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT Arthur Sloan
 (ADDRESS) Lawrence
 18. BURIAL INFORMATION, OR REMOVAL PLACE Dennis Cemetery DATE 2-1-1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) _____
 20. FILED _____ 19 _____
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-31, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 1/17, 1938, to 1/31, 1939.
 I last saw him alive on 1/26, 1939. Death is said to have occurred on the date stated above, at 5:15 a.m.
 The principal cause of death and related causes of importance were as follows:
Chronic nephritis interstitial & prostatic Date of onset _____
 Other contributory causes of importance: 131
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) R. A. Ryan, M. D.
 (Address) Monte Grant

WRITE PLAINLY, WITH ORANGE INK--THIS IS A PERMANENT RECORD

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 impor

RECEIVED

District Health Officer No. 6,

District File Number 6-5-39-1028

Date Filed May 8, 1939

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

14763
Do not use this space.

1. PLACE OF DEATH
 (a) County Douglas Registration District No. 276
 (b) Township Wood Primary Registration District No. 5389
 (c) City _____ (d) Street No. _____ Registered No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Geo Washington Sloan
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-4-1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>71</u>	<u>0</u>	<u>27</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER
 13. NAME John Sloan
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
 15. MAIDEN NAME Mary Rogers
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Arthur Sloan
plow

18. BURIAL, CREMATION, OR REMOVAL PLACE Penner Cew DATE 2-1-1939

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED June 2, 1939 Trilba Sims
Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-31-1939

22. I HEREBY CERTIFY, That I attended deceased from 1-17-1939 to 1-31-1939
 I last saw h. alive 26, 1939. Death is said to have occurred on the date stated above, at 8 A. m.
 The principal cause of death and related causes of importance were as follows:
Chesteria meningitidis
Intestinal and prostatic
 Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) R. A. Ryan, M. D.
 (Address) mtw plow

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

