

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

JUN 22 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

19007

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

Registration District No. 562Primary Registration District No. 5757

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County Miller  
(b) City or town Iberia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution \_\_\_\_\_

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community Life  
years, months or days \_\_\_\_\_3. (a) PRINT FULL NAME PHOEBE CAROLINE SLAWSON

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No.
- None

4. Sex
- Female
5. Color or race
- white
6. (a) Single, widowed, married, divorced
- Married

6. (b) Name of husband or wife
- Charles R. Slawson
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased
- March 26 - 1877
- 
- (Month) (Day) (Year)

8. AGE: Years
- 63
- Months
- 24
- Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace
- Miller Co., MO.
- 
- (City, town, or county) (State or foreign country)

10. Usual occupation
- Housekeeper

## 11. Industry or business \_\_\_\_\_

12. Name
- James Blyze

13. Birthplace
- unknown
- 
- (City, town, or county) (State or foreign country)

14. Maiden name
- Maury Jane Beard

15. Birthplace
- unknown
- 
- (City, town, or county) (State or foreign country)

16. (a) Informant's own signature
- Charles Slawson

- (b) Address
- Iberia, MO

17. (a)
- Buried
- (b) Date thereof
- Apr 21 - 1940
- 
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation
- Medden Cem Iberia, MO.

18. (a) Signature of funeral director
- St. Boney

- (b) Address
- Iberia, MO.

19. (a)
- May 10
- (b)
- Mrs. W. A. Von Gray
- 
- (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State
- MO
- (b) County
- Miller
- 
- (c) City or town
- 0 Rural
- 
- (If outside city or town limits, write "RURAL")

- (d) Street No.
- Iberia, MO. R# 2
- 
- (If rural, give location)

- (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- April
- day
- 20
- 
- year
- 1940
- hour
- 12
- minutes
- 5
- P. M.

21. I hereby certify that I attended the deceased from
- Apr. 2
- 
- 19
- 40
- , to
- Apr. 10
- , 19
- 40
- 
- that I last saw her alive on
- Apr 15
- , 19
- 40
- 
- and that death occurred on the date and hour stated above.

- Immediate cause of death
- Tuberculosis pulmonary
- 
- chronic
- 
- Due to
- pneumonia, bronchial
- 
- Apr. 1 to Apr. 10th
- 
- Due to \_\_\_\_\_

Duration

15 yrs10 days

- Other conditions \_\_\_\_\_
- 
- (Include pregnancy within 3 months of death)

- Major findings:
- None
- 
- Of operations \_\_\_\_\_

- Of autopsy
- None

PHYSICIAN

Underline the cause to which death should be charged statistically

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)
- as

- (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?
- 
- Y

- While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature
- C. Mallett
- (M. D. or other) \_\_\_\_\_

- Address
- Crocker, Mo.
- Date signed
- 4/22/40

RECEIVED

Miller County Health Dept

County File Number 40-65

Date Filed 6-10-40

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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.....

Laron Adams....., Registered Apprentice No. 911  
working under my personal supervision.

Signed Ch. Casey.....

Licensed Embalmer No. 9694

P. O. Address Brva, 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, above space should be left blank.