

No. 2  
1-13-40  
-17-30

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42819

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

JAN 17 1941

Registration District No. 395

Primary Registration District No. 5551A

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

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson County  
(b) City or town Rural Sni-a-bar  
(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 2 months 15 days \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Edward Green Slater

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mollie Elizabeth Sturges 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased Jan 7 1872  
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Davis County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farm

12. Name Robert Slater

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

14. Maiden name Elizabeth Walker

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

16. (a) Informant Clyde Slater

(b) Address Strain Valley, Mo. R.F.D. I

17. (a) Removal (b) Date thereof Nov 19 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prairie Ridge

18. (a) Signature of funeral director Libson & Son

(b) Address Orick Mo

19. (a) 11/19/40 (b) Mrs. Thomas Bartland by Dr. G. E. Query  
(Date received local registrar) (Registered signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1 1/2 miles West of Strain Valley  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? X years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19  
year 1940 hour 9 minute — a.m.

21. I hereby certify that I attended the deceased from 11/18/40  
\_\_\_\_\_, 19\_\_\_\_, to 11/19/1940  
that I last saw him alive on 11/18/1940  
and that death occurred on the date and hour stated above.

Immediate cause of death CARDIOVASCULAR - RENAL DISEASE

Due to \_\_\_\_\_

Due to 121

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? \_\_\_\_\_

921 (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature G. E. Query (M. D. or other) 3

Address Orick Springs Date signed 11/19/40

**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. 4137.....

P. O. Address Creick, 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.**