FILLED JUN 13 1941

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

Do not use this space.

1. PLACE OF DEATH
County Polk — Registration District No. 707 — File No. 18752
Township East Jonney — Primary Registration District No. 3-936 — Registered No. 9
City Morrisville (No. 1 St. Ward)

2. FULL NAME William Junceford Slagle
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Emily J. Slagle

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27 1844

7. AGE: 85 YEARS — MONTHS: 9 — DAYS: 14 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Near Morrisville
(STATE OR COUNTRY) Morrisville Mo.

PARENTS
10. NAME OF FATHER Abraham Slagle
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Martha Junceford
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee

14. INFORMANT Byron Slagle
(Address) Morrisville, Mo.

15. FILED Mar 14 1929 Mrs. Hattie M. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar, 11, 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to Mar, 11, 1929 that I last saw him alive on Mar 10, 1929, and that death occurred, on the date stated above, at 1:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer or Face

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 5 yr
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. H. Bridges, M. D
Mar 11, 1929 (Address) Bolivar, Mo

*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: Slagle Cem — DATE OF BURIAL: Mar 12 1929

20. UNDERTAKER: N. S. White Hard Co — ADDRESS: Bolivar Mo

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.

RECEIVED
District Health Officer No. 7,
District File Number 6-41-1009
Date Filed 6-11-41

2B
5-41
X/652

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18752

Registration District No. Polk 707 Primary Registration District No. 5936 Registrar's No. 9

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Polk

(b) City or town E. Looney (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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk

(c) City or town Morrisville Rural (If outside city or town limits, write "RURAL")

(d) ~~Street~~ No. R-1 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Wm Lunceford Slagle

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

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

8. AGE: Years 85 Months 9 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Aug-10-41 (Date received local registrar) (b) Hillard E Dickinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 11 year 1939 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. H. Bridges (M. D. or other)

Address Bolivar Mo Date signed

S-18752 1941