

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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 important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11207

State File No. _____

Registrar's No. 9

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
FILED APR 9 1942

Registration District No. 490

Primary Registration District No. 5649

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Elsbury Rural
(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 1

3. (a) PRINT FULL NAME William Jefferson Sladd

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maggie Colman Stone Sladd 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 16 1875
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Lincoln County Mo (City, town, or county) Hiram (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name William Sladd

13. Birthplace Virginia (State or foreign country)

14. Maiden name Mary Ellen Barnes

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

16. (a) Informant's own signature Mrs Maggie Sladd

(b) Address Elsbury, Missouri

17. (a) _____ (b) Date thereof May 23 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elsbury Cemetery

18. (a) Signature of funeral director Clifton ...

(b) Address Elsbury, Mo.

19. (a) 4/6 1942 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln

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

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22nd year 1942 hour 8 minutes 30 M.

21. I hereby certify that I attended the deceased from July 1941 to March - 20 1942

that I last saw him alive on Mon. 20 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Sudden Duration _____

Due to Subacute Dissecting aortic aneurysm

Due to Chronic Summits 5y

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 93d

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? _____

While at work? _____ (Specify type of place) (Means of injury)

23. Signature R. J. Keelin (M. D. or other) _____

Address Elsbury, Mo. Date signed May 23 1942

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 John 227

....., Registered Apprentice No.....
working under my personal supervision.

Signed Clifton Miller
Licensed Embalmer No. 3364
P. O. Address Eleberry, Md.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11207

Registration District No. 490

Primary Registration District No. 5649

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Rural
(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 _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

William J. Sledd

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. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 16
(Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days _____
If less than one day _____ min.

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

10. Usual occupation _____
11. Industry of business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 4/6/1942 (b) William Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19____
that I have a law which will live on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

11207

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