

Registration District No. **47** Primary Registration District No. **3008**

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1  
2  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution: State Hosp no. 12  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 134 3m  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County St Louis

(c) City or town St Louis  
(If outside city or town limits, write "RURAL") 2

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Eligial B. Slungo

3. (b) If veteran, name war A. H. 3. (c) Social Security No. R. H.

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

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

7. Birth date of deceased March 31 1871  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Dec day 19 year 1943 hour 10 minute 20 M.

21. I hereby certify that I attended the deceased from 11-20 1942 to 12-19 1943; that I last saw him alive on 12-19 1943 and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 9 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death chronic myocarditis

Due to Old Hemiplegia

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.

9. Birthplace Texas (City, town, or county) \_\_\_\_\_ (State or foreign country) 1

10. Usual occupation Laborer

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

MOTHER FATHER { 12. Name not given

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

14. Maiden name not given

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

16. (a) Informant Record

(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 12-21-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia MO

18. (a) Signature of funeral director J. O. Roberts

(b) Address Columbia MO

19. (a) 12-20-1943 (b) Jose Morosoff  
(Date received local registrar) (Registrar's signature)

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)

(e) Means of injury \_\_\_\_\_

23. Signature R. E. Sturritt (M. D. or other) \_\_\_\_\_

Address Fulton MO Date signed 12/20/43

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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.....  
....., 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, fact should be so stated above.**