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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9262**

Registration District No. **46**

Primary Registration District No. **5151**

Registrar's No. **24**

1. PLACE OF DEATH:
(a) County **Caldwell**
(b) City or town **Rural Riddon Twp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3 miles south east of Cameron
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **NO**
(Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Caldwell**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **3 miles south east of Cameron**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **✓**

3. (a) PRINT FULL NAME **J Taylor Sloan**
(b) If veteran, name war **✓**
(c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **13**
year **1945** hour **3:45 A** minute **19** M.
21. I hereby certify that I attended the deceased from
Jan 42 to Feb 13 45
that I last saw him alive on **Feb 2 1945**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **1**
(b) Name of husband or wife **Mary Ada Sloan**
(c) Age of husband or wife if alive **70** years
7. Birth date of deceased **Sept 2 1873**
(Month) (Day) (Year)

Immediate cause of death
Chronic interstitial Nephritis
Due to **39 years**
Duration

8. AGE: Years **71** Months **6** Days **10**
If less than one day hr. min.

Due to
Other conditions (include pregnancy within 3 months of death)

9. Birthplace **Wayne Co Kentucky**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**

Major findings: Of operations **1312**
Of autopsy

11. Industry or business
12. Name **Thomas Sloan**
13. Birthplace **Wayne Co Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Polly Hunt**
15. Birthplace **Wayne Co Kentucky**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Fred Sloan**
(b) Address **Cameron**

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?

17. (a) **Rural** (b) Date thereof **2-14-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Miracle Mo.**

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

18. (a) Signature of funeral director **John F. ...**
(b) Address **Cameron**
19. (a) **Feb 15 45** (b) **Cornelius Garrett**
(Date received local registrar) (Registrar's signature)

23. Signature **A. O. ...** (M. D. or other)
Address **Cameron Mo** Date signed **Feb 14 1945**

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

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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.....

[Handwritten Signature]
.....
Licensed Embalmer No. 3960

P.O. Address Maysville, 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, fact should be so stated above.

Registration District No. 46 Primary Registration District No. 5151

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

1. PLACE OF DEATH:

(a) County Caldwell

(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

3. (a) PRINT FULL NAME J. Taylor Sloan

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 Married

6. (b) Name of husband or wife Jimmy 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Sept 3
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days _____ (less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) Feb 15 - 45 (b) Corvaine Lane
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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 _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

9262