S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 18 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8394

Registration District No. 4 Primary Registration District No. 4012 Registrar's No.

1. PLACE OF DEATH:

(a) County ATCHISON

(b) City or town ROCK PORT (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 (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 MO (b) County ATCHISON 3

(c) City or town ROCK PORT. 1 (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME JOSEPH SLATER

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MALE 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife

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

7. Birth date of deceased 12 (Month) 25 (Day) 1863 (Year)

8. AGE: Years 82 Months 2 Days 12 If less than one day hr. min.

9. Birthplace EGERTON (City, town, or county) OHIO (State or foreign country) 1

10. Usual occupation RETIRED FARMER

11. Industry or business

FATHER
12. Name THOMAS SLATER 6
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country) 1

MOTHER
14. Maiden name SUSAN KYLE
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country) 9

16. (a) Informant Lottie Slater

(b) Address ROCK PORT

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-9-46 (Month) (Day) (Year)

(c) Place: burial or cremation GREEHILL CEM

18. (a) Signature of funeral director BARTHOLOMEW MORTUARY

(b) Address ROCK PORT. MO

19. (a) 3-7-46 (Date received local registrar) (b) Betty Crabtree (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1946 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from March 4, 1946, to March 7, 1946 that I last saw him alive on Mar 7, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal perforation c̄ peritonitis	4 hrs
Due to: Hernia strangulated left inguinal	3 days
Due to	
Other conditions: Myocarditis severe c̄ auricular fibrillation (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 Emmett B. Seale (M. D. or other) MD

Address Rock Port, Mo Date signed 2 Mar 46

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(Licensed Embalmer's Statement on Reverse Side)

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. Gratz Bartholomew

Licensed Embalmer No. 3173

P. O. Address. Rock Port, 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.