

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Fikeville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
416 S. Main Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1 yr
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Fikeville
(If outside city or town limits, write "RURAL")
(d) Street No. 416 S. Main
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES ROBERT SLOAN

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M!

6. (b) Name of husband or wife Louisa 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased July 6 1857
(Month) (Day) (Year)

8. AGE: Years 89 Months 5 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Columbus Sloan
13. Birthplace unknown Tennessee
(City, town, or county) (State or foreign country)
14. Maiden name Rebecca Thompson
15. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Phoebe Dodson

(b) Address 416 S. Main Street, Fikeville, Mo.

17. (a) Burial (b) Date thereof 12-16-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atlanta, Missouri

18. (a) Signature of funeral director Summers & Powell

(b) Address Fikeville, Missouri

19. (a) 12-17-46 (b) Wate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13 year 1946 hour 11:00 minute A.M.

21. I hereby certify that I attended the deceased from 12/17/46 to 12/13/46 and that death occurred on the date and hour stated above.

that I last saw him alive on 12/16 1946
Immediate cause of death Chronic Myocarditis of coronary arteries with Cardiac Asthma

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

Major findings: Of operations MI
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) (e) Means of injury 2

23. Signature W. H. Summers (M. D. or other) MD
Address Fikeville Mo Date signed 12/17/46

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

38302

RECEIVED
District Health Officer No. 10
District File Number 12-46-2345
Date Filed DEC 24 1946

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 W. L. Summers

Licensed Embalmer No. 2159

P. O. Address Wicksville 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.