

No. 2  
4-5-43  
5-17-39  
K36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1448  
Registrar's No. 26

FILED FEB 10 1947

Primary Registration District No. 3026

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

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Independence Sanitarium  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution Sanitarium Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12 days  
 (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
 years, months or days

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

4. Sex Male 5. Color or race W  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Helen Sloan  
 6. (c) Age of husband or wife if alive 57 years  
 7. Birth date of deceased Oct 15 1889  
 (Month) (Day) (Year)

8. AGE: Years 58 Months 3 Days 14  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Jeweler

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

MOTHER FATHER

12. Name J. S. Sloan

13. Birthplace Kentucky  
 (City, town, or county) (State or foreign country)

14. Maiden name Nancy C. Staniford

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

16. (a) Informant Mrs. Sherman Sloan

(b) Address Cameron Mo.

17. (a) Burial (b) Date thereof 1-31-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cameron Mo.

18. (a) Signature of funeral director Palmer H. Hoxby

(b) Address Cameron

19. (a) 1-30-47 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clinton 25  
 (c) City or town Cameron  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29  
 year 1947 hour \_\_\_\_\_ minute 4:14 P.M.

21. I hereby certify that I attended the deceased from 1/17 1947 to 1/29 1947  
 that I last saw him alive on 1/29 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (rt)  
 Due to Hypertensive cardiovascular disease  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration 2 weeks

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy 93D

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 0

23. Signature Janice E. Link, M.D. (M. D. or other) \_\_\_\_\_  
 Address 119 W. Lexington, Independence, Mo. Date signed 1/29/47

FEB 24 1967

2-10-67  
M-3-4  
1824X

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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..... *B. D. Nelson* .....

Licensed Embalmer No. *4421* .....

P. O. Address *Cameron, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 26Registration District No. 146Primary Registration District No. 3026Registrar's No. 26

## 1. PLACE OF DEATH:

(a) County Jackson(b) City or town Independence

(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 days3. (a) PRINT  
FULL NAME Sherman Sloan3. (b) If veteran,  
name war \_\_\_\_\_3 (c) Social Security  
No. \_\_\_\_\_4. Sex M5. Color or  
race W6. (a) Single, widowed, married,  
divorced M

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_7. Birth date of deceased: Oct 15

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

5733

hr.

min.

9. Birthplace Ind. Mo.

(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) \_\_\_\_\_

(Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) \_\_\_\_\_

(Date received local registrar)

(b) J. M. Sloan

(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 \_\_\_\_\_ Day \_\_\_\_\_

year 1947

(hour) \_\_\_\_\_

minute \_\_\_\_\_

M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_

19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

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.

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 29

5-1448